VA HEALTH CARE FOR WOMEN AND H.R. 1137

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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VA HEALTH CARE FOR WOMEN VETERANS AND H.R. 1137

THURSDAY, MARCH 3, 1983

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Mica, Evans, Kaptur, Mollohan, Penny, Staggers, Rowland, Richardson, Daschle, Hammerschmidt, Solomon, McEwen, Smith of New Jersey, Bilirakis, and Johnson.

Also present: Representatives G. V. (Sonny) Montgomery (ex officio) and Don Edwards.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. **Edgar**. The Subcommittee on Hospitals and Health Care will come to order.

I would like to welcome everyone here this morning for a very unique hearing. I would just like to say at the outset that we hope that, as important as this hearing is, and as important as it is to have a thorough hearing, that because of the pressures of House debate on the jobs legislation, that we can keep the hearing schedule and hopefully hear adequately from all the witnesses in about a 2½-hour process.

The purpose of this morning's hearing is to receive testimony on the current status and projected need for VA health care services for women veterans. The hearing is also designed to receive testimony on H.R. 1137, legislation Congressman Don Edwards and I introduced to amend title 38, United States Code, to establish by statute a women's advisory committee within the Veterans' Administration.

Current data from the 1980 census indicate that the female veteran population has risen from recent estimates of approximately 750,000 to over 1.1 million. Women have made major contributions to the defense of our country in the past, but the nature of modern warfare, and the growth of high technology weapons systems will insure an even greater participation of women within the military in years to come.

During this decade, a shrinking pool of 18- and 19-year-old males available for military service will present an ever-larger need for women to volunteer for the armed services. Over the next 5 years the Department of Defense estimates that the number of women in the service will increase from 191,000 to 218,000 women. This expanded role for women in the Armed Forces will also create additional responsibilities for the subcommittee and the Veterans Administration.

We intend to see that equality of military service is matched by equal rights and benefits provided through the Veterans' Administration for all veterans, regardless of sex, age, or race.

It is very clear that inequities for women veterans have existed in the past. For instance, until 1972, married female veterans, received smaller education allowances under the GI bill than did married male veterans. In the 1960's, the VA did not consider a woman's income equal to a man's for the purpose of qualifying for home-loan guarantees. This overt discrimination is behind us. But, at the present time, we are still attempting to grapple with the problems and needs of women veterans without adequate statistical evidence and analytical tools to address these needs.

As just one example, with growing evidence of unique readjustment disabilities or potential health problems among female Vietnam veterans, unbelievably no one right now even knows how many women actually served in Vietnam.

I have introduced H.R. 1443, with the cosponsorship of Mr. Edwards, which calls for a new, thorough reexamination of the readjustment status of Vietnam era veterans to include specific analysis of the extent of health problems among women veterans. I am encouraged to hear that the Veterans' Administration has already planned for a statistical review of this population as well.

On September 24, 1982, the General Accounting Office published a report entitled "Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits." The report concluded that while the VA has made progress in insuring that medical care and other benefits are available to eligible female veterans, there still remain certain deficiencies in providing services, to meet the needs for that veteran population.

We will receive a review of those deficiencies from the General Accounting Office this morning. We will also hear from VA officials as to the positive steps they have taken in recent weeks to comply with the recommendations set forth by GAO. The subcommittee is encouraged by the initiatives taken under the leadership of the new VA Administrator, Harry Walters, in this regard.

We are also pleased that the Administrator has endorsed the concept of developing an Advisory Committee on Women Veterans' within the VA. The Veterans' Administration would establish the committee by administrative action. The legislation which has been introduced, H.R. 1137, would establish the Advisory Committee on Women Veterans by law. The committee would then be appointed by the Administrator who shall determine the number of members, their terms of service, and pay. It would also require a biennial report from the Advisory Committee to the Committees on Veterans' Affairs and to the Administrator on the programs and activities of the VA as they pertain to women veterans.

In my opinion, this legislation is urgently needed. The legislative and executive branches of the Federal Government should share in the responsibility for planning and providing quality benefits for all women who have served in defense of this country.

I look forward to the testimony we will receive today, and I would first like to recognize the ranking minority member of the subcommittee, the Honorable John Paul Hammerschmidt, for any opening comments that he might have.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. **Hammerschmidt**. Thank you, Mr. Chairman. I want to congratulate you and our very able colleague, Mr. Edwards, for your initiative in the legislation and for holding these hearings this morning.

Our hearing this morning focuses, of course, on the basic issue of whether appropriate services are being provided by the Veterans' Administration to women veterans, particularly in the medical field. In times past, I think it rather clear that equal medical services have often not been available to these women. This resulted, in part, in the fact that many VA hospitals did not have the proper capability and staffing to render such services and in many instances were not constructed to provide the necessary privacy. It resulted, too, from the fact that over the past few years ambulatory care has greatly expanded in the VA system for nonservice connected conditions. A nonservice connected male veteran would routinely be given such care for almost any condition to obviate the need for hospitalization, while a female veteran would not receive it for certain conditions, because the hospital or clinic did not have the proper treatment capability and could not legally contract for it within the private sector.

In this connection, authority does exist within the law for such contracting for inpatient care and for post hospital care. Authority also exists to bring specialty physicians into VA hospitals as consulting and attending doctors.

However, Mr. Chairman, as I understand it, these individuals could not be used for a fee basis or contract outpatient treatment. Perhaps, Mr. Chairman, we ought to consider changing the law on this. Perhaps there could be an equitable, an inexpensive way of solving part of this problem.

Mr. Chairman, as you have stated, the GAO has delved extensively into this subject and has made a number of recommendations. The VA has moved to implement those recommendations in a very positive way. I look forward to Dr. Custis discussing the actions that have been taken, or will be taken, and I also look foward to hearing our other witnesses who are scheduled to testify this morning, and I particularly can't help but mention the one at the witness table right now, Sarah McClendon, who we all know and have known for a long time. We are delighted that she is with us this morning.

Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you very much.

I would like to yield now for an opening statement, to my colleague from California, Mr. Edwards, who helped to initiate this hearing this morning. I want to thank him for his efforts.

Mr. **Edwards**. Thank you, Mr. Chairman. I appreciate your allowing me to sit in with this distinguished subcommittee this morning on this very important legislation. I compliment you for moving so quickly on it. It is really very important.

I have a statement that I would like to present for the record.

Mr. **Edgar**. Without objection, the full statement will be made a part of the record.

Mr. **Edwards**. Thank you very much.

[The statement of Mr. Edwards appears at p. 67.]

Mr. **Edgar**. Are there any other opening statements?

We actually have a number of distinguished witnesses this morning who have come and prepared testimony on this important issue. I would like to call to the witness stand Miss Lynda Van DeVanter, National Women's Director of the Vietnam Veterans of America and she is joined at the witness table by Mrs. Sarah McClendon. We have asked Lynda Van DeVanter to come and speak first, and then we will hear from Mrs. McClendon.

Ms. Van DeVanter is the National Women's Director of the Vietnam Veterans of America, one of the leading advocates and spokespersons for women Vietnam veterans in this country. She served as a combat nurse in Vietnam. We are very pleased to have you here.

We will make your full statement a part of the record at this time, without objection, and we invite you to proceed. We are anxious to hear your testimony.

STATEMENTS OF LYNDA M. VAN DeVANTER, NATIONAL WOMEN'S DIRECTOR, VIETNAM VETERANS OF AMERICA; AND SARAH McCLENDON, WHITE HOUSE CORRESPONDENT

STATEMENT OF LYNDA M. VAN DeVANTER

Ms. **Van DeVanter**. Thank you, Mr. Chairman.

My name is Lynda Van DeVanter and I am the National Women's Director of Vietnam Veterans of America. I am honored and gratified to be here before this committee, to at least begin to address women veterans, a significant population of our veteran community.

Women veterans historically have been the subject of apathy, from the Government, from the Veterans' Administration, from agencies which were directed to address the issues of those individuals who have served this country. As Mr. Edgar mentioned, even the numbers of women who served in certain kinds of situations, specifically in Vietnam, have been almost impossible to obtain.

I want to just summarize briefly my testimony, and the areas which I have addressed in my testimony, which address the specifics of this particular Subcommittee on Hospitals and Health Care. Those are areas related to physical medical care, mental health care, service connection and compensation for medical conditions, toxic chemical exposure, and research issues.

First of all, in the area of physical medical care, we have seen very clearly from the GAO report that the Veterans' Administration's medical facilities are not providing adequate physical medical care in many situations for women veterans. The most elemental health care need of a female veteran is gynecological care. In many, many situations that care is unavailable or, if available, the women are not being informed that they can utilize contract fees for services, or they are just simply being told there is no availability of those programs. In some cases women are being given a runaround, being told by one person in the VAMC that there is availability, and being told by others that there is no availability.

It is clear that all kinds of care are provided to male veterans, regardless of service connection. In the situation with gynecological care, if the female is not service connected, she cannot get contract fee for service care. That is a clear discrimination against that population of veterans.

We have suggested a number of options that might be taken in order to assure proper care in this area. First of all, establishing working agreements with DOD medical facilities, since Army, Navy, Air Force medical facilities not only treat females who are in the service, but also treat family members of those male service members. They do have availability of GYN services.

Second, the possibility of establishing working agreements with VA affiliated medical schools or teaching hospitals with gynecological departments. An arrangement could be made to provide oncall service or to provide an individual qualified gynecologist who could be available 1 or 2 days a week, depending on the need for such care.

Third, providing contract fee for service. This is supposed to be provided, but the reality is it is not being provided. I have done a survey myself of approximately 15 VAMC's, and in those 15 VAMC's never was I told that I was entitled—When I did the survey I stated clearly up front that I was a service connected female Vietnam veteran and required gynecological care. In no case, except one, was I told that I was entitled to contract fee for service care. In every case I was told "we don't have that provision; we don't have that ability to provide for that care."

In one case I decided I would push that through, until I got the answer I wanted. I went through seven different offices until I got to the chief of staff of the hospital, where I was again told that there was no provision for that care at that particular facility. At that point I said I am entitled to the care and I know I am entitled to the care, and you have to provide it. At that point only was I told, "Oh, yes, by the way, you are entitled to contract fee for service."

In the area of general medical care there are also problems. Many of the VAMC's don't have proper privacy facilities for women who are hospitalized. At times there are 1 or 2 women in a large ward of 30 or 40 men; there are no separate "john" facilities, no separate shower facilities. If the female wants to use those facilities, somebody has to guard the door to protect their privacy.

The answer is not necessarily—and in some cases in the VAMC's the woman will be transferred to another ward where she can have better privacy. The answer is not necessarily that in many situations. If you have, for instance, an orthopedic patient, and that orthopedic patient is placed on a medical ward because the medical ward is the one that has the privacy, the nursing staff on the medical ward are not properly trained to handle the equipment, the procedures, the medications, and the treatments for an orthopedic patient. Therefore, the female veteran who is in that kind of position is going to receive substandard care.

Second, if the physician does not have that patient right in front of him, it becomes a case of "out of sight, out of mind." So if the woman who is an orthopedic patient, is way over on the medical ward which is three blocks away, she is not only not going to get standard care, she is also not going to get standard medical care.

In the mental health area, numerous studies have been done of the mental health issues related to male veterans of all eras. In none of the Veterans' Administration studies to date, have any females been included in any of those studies, even the recent multiyear, multimillion dollar study of the mental health capacities and issues related to Vietnam era veterans which was contracted by the Congress through the Veterans' Administration to the Center for Policy Research in New York. In that case, it was one of the most comprehensive studies that has ever been done. Yet female veterans still were not included.

The only research which has been done was done by Jenny Schnaier, a graduate student at the University of Maryland, who is here this morning and will present the findings of her study.

We at the Vietnam Veterans of America funded that study. That is inappropriate. It is important that that study got funded, but those kinds of things are supposed to be funded by the Veterans' Administration. The VA has a research budget annually in excess of $150 million. They have not spent anything to research women veterans—and we're not just talking about women Vietnam veterans; we are talking about women veterans of all eras.

We have women who served, and were held as prisoners of war in Corregidor during World War II. We have women who were under hostile fire in many kinds of situations, and in the future of the military, with an increasing percentage of women who are in the military, they are going to be subjected to more situations where they will be in combat situations. They have already been under combat situations, despite what everybody would like to convince you. In the Women in the Army Study, women have been in combat ever since the beginning of time, and especially ever since the beginning of this country. They have been subjected to those things, they have been subjected to the psychological effects of them, and we have a responsibility to address those issues and find out if those women are properly being taken care of, and if they do have remaining issues.

The Veterans' Administration readjustment counseling program has begun to address women. There are still problems within that program and the Director, recognizing those problems, established a working group on women veterans to begin to evaluate what kinds of issues needed to be dealt with in the vet center program, and that working group's recommendations are beginning to be implemented. There is still more that is needed in that area and we must make sure that that continues.

In the area of toxic chemical exposure, women have been subjected to exposure to agent orange and other toxic chemicals in Vietnam and, I assume—although we don't have any information because they have not been studied—also to those kinds of things that occurred in the fifties as far as atomic testing is concerned. Women must be included in these studies.

The Veterans' Administration and the Scientific Advisory Panel have declined to include women in the agent orange studies which are presently being done. They say it is because there are too few of us. That's absurd. They don't even know how many of us there are. However, there are a minimum of 7,000 to 8,000 of us, and that is way over the numbers of the people that they are studying in the Ranch Hand population and in the twin populations in which you have a group of 1,200 and approximately 400, although we probably aren't going to get more than 30 or 40 sets of twins where 1 of them was in Vietnam and 1 of them was not.

The female population, according to all the EPA studies and the animal studies, is clearly more highly susceptible to the reproductive toxic side effects of agent orange as compared to males. And yet that population, which is more susceptible, is not going to be studied. Clearly, we are in a situation of a Catch-22 area.

I want to quickly run over the advisory committee. We are deeply grateful that Mr. Edgar and Mr. Edwards have submitted this legislation. We have a 4-year history with the Veterans' Administration of requesting the VA to establish such an advisory panel. We have had five different answers from three different Administrators during that 4 years. The answers constantly went back and forth, from yes to no, yes to no, yes to no.

We are deeply pleased and deeply grateful that the new Administrator, Mr. Walters, has come in and has said very clearly up front that he is supportive of this idea and he is supportive of having an advisory committee, and he has already begun the steps to establish it. We are very pleased about that. However, we don't want to have to come back here in 2 years or 6 years, where there is a new Administrator, and depending on the political vagaries of a particular situation at that time, that particular Administrator decides that there is no need for an advisory committee on female veterans. We feel it must be established legislatively.

I know that I have gone over my time, but I deeply appreciate your willingness to hear us and I look forward to hearing the rest of the comments of the witnesses.

Thank you.

[The statement of Lynda Van DeVanter appears at p. 67.]

Mr. EDGAR. Thank you very much. Your statement is very helpful.

Before we move to questions on your statement, I would like to call on our second witness. I think if you look from this vantage point and see the name tags, Sarah McClendon's name tag is a little larger. I think it represents the kind of contribution that she has made.

Sarah is a nationally recognized journalist, a White House correspondent, and a former member of the Defense Advisory Committee on Women in the Service. Mrs. McClendon is a World War II veteran, an advisor to the Department of Defense on women's issues, and I think one thing in her recognition is also that she is just about the only person in the past 2 years who has been able to get the President of the United States to stop and to listen on the issue of women.

Sarah, we are very pleased that you are here today and we look forward to hearing your statement. The full text of your statement will be made a part of the record.

STATEMENT OF SARAH McCLENDON

Mrs. **McClendon**. Thank you so much, sir. I appreciate that very much, and we are deeply grateful to you for having this hearing, the first I understand on women veterans problems.

You are going to have to hear a lot more about women veterans in the future, because up until now we estimate—I think we differ a little bit with the VA—but we estimate that there have been less than 2 percent women veterans in the past, but we are going to have 10 times that many, and you're going to have 10 times more women veterans in the future. When you look at the jobs they do, and if they are in combat, and have been in combat, there will be women brought home in body bags, but there will be a lot of them maimed and crippled in any future wars that we have.

I want to say that we need equal facilities for women in these veterans hospitals. I am sick and tired of hearing of some women being referred to go out and get gynecological aid. I know myself, as a veteran, I would put that off, I would delay that, I wouldn't do it, I would wait. And if it was right there in the hospital where I was entitled to go, I would use it. I would go there and get it.

Now, it seems that one woman has written in—Ann Pace from California wrote to the Women's Overseas Service League, that she neglected to go for this treatment, because she wasn't sure about where she would go. So when she got there, she was 3 months too late. Now she is dying of cancer.

We have another problem with the Veterans' Administration. They don't care anything about the women when they know they have got cancer, and know they're going to die. They turn them out. Here is a pathetic letter—I didn't get this in my statement, but I have got several copies of it here. It is a pathetic letter of an Air Force nurse, after years of service, and when they found out she had cancer, the Veterans Hospital turned her out. She didn't have a home. She didn't have any place to go. Friends of hers had to come along and take care of her.

Mr. **Edgar**. Without objection, that letter will be made a part of the record.

Mrs. **McClendon**. Thank you very much.

[The letter appears at p. 73.]

Mrs. **McClendon**. Now, Gabriella Gouveia, sergeant, 21 years experience in the Army—Gabriella, stand up. Gabriella is one of these people who has been out at this great, wonderful·Washington hospital over here in the District of Columbia. She had to make her own handwritten signs when she wanted to take a shower, put it up on the door, or else get a man to stand outside the door to guard the door because it just says "showers"; it doesn't say whether it is for men or women. They know better than that.

Also, Gabriella has found many things over there. It's a cold hospital sometimes. She was a heart patient. She was brought over there by ambulance, and after she got there, she had to wait for hours to be admitted. The paperwork had to go through, and then they put her in a cold room. There is no excuse for that. That's not good for heart patients, and besides, that boiler out there I understand breaks down every now and then. Anyway, there should be no veteran, man or woman, in a cold room.

There is no place out there for self-care wards for women. Lots of men and women patients have to brush their teeth over the bathtub. That's stupid. Sometimes they don't even have bathtubs. Gabriella took a sponge bath out there for 2 weeks one time. That's disgusting.

Then she went out there with an injured shoulder and they told her there was nothing wrong with her shoulder. She's a retiree, so she went over to Walter Reed and they found she had a broken shoulder. There is no excuse for that.

They sent Gabriella home one time—they knew she had no one at home to take care of her. They sent her to her home out here in Arlington and told her to stay in bed, only to get up to get something out of the refrigerator. What is she going to do about hot meals? There is too much of that.

There are lots of men ambulatory patients over there who could go home and have somebody there to take care of them. They can go to the tourist exhibits downtown, but they are left in the hospital as patients, often when women are sent home where they don't have anyone to take care of them. That's not just.

I want to caution you, when you get these statements from the veterans hospitals about what they are doing and how great they are and everything, I want you to look very carefully at how general they are and how they are nonspecific. They don't really tell you what they are and are not doing. I'm not satisfied with those comments of the Veterans' Administration on the General Accounting Office's draft report of July 21, 1982, enclosure (3), page 23. There is no specific promise to produce better service; only bureaucratic double talk, such as "VA will develop guidelines to assist in improving access to outpatient gynecological care." That's what we have now. We want something better than that. We don't want outpatient gynecological care.

The VA says, "It will provide the special facilities needed for the treatment of female veterans when the VA's health care programs require these facilities." Well, the time is now.

Continuing, the VA says "Interim solutions are often necessary, even though they require a compromise in program scope and staff convenience." Well, you will have to translate that bureaucratic talk to me, to understand what the heck they mean there. I think it means that Sergeant Gouveia is going to have to keep on making her little signs, in order to have a private shower out there.

As to the future load that we can expect in the way of more women patients, let me point out—well, we couldn't exactly find out, but Jeanne Holm, a major general of the Air Force, who has done a great book here, "Women in the Military"—and I have brought a copy to give to the committee at Jeanne's request for their library. She has a lot in here about veterans as well as women on active duty.

She thinks there were about 5,700 women in Vietnam. They wanted more women over there but the Army didn't want them there. Jeanne worked hard when she was in the service to get them over there. I think there would have been a lot of men who wouldn't have had to be drafted if they had acceded to the request and sent more women to Vietnam. But aside from that, we think that you have got at least 5,700 women, and maybe many, many more from Vietnam.

You have got 350,000 women who served in World War II, and a lot of those women I want you to know have not yet gotten to the Veterans Hospitals, but they're coming. We have one of them over here, Georgia Surrell, in the audience. Georgia, stand up. Georgia was one of those people in the South Pacific where these women suffered great hardships for months. You will find many of those women from World War II are going to have to be patients of the veterans hospitals. They slept in tents with rats and mosquitoes for months. They had no solid food which developed constipation problems and menstrual problems. They suffered all kinds of hardships there. They had a boot on that the Army gave them, that rotted on their feet in that damp climate. So you are going to have a lot more women veterans in hospitals.

You also have 100 women veterans from World War I, according to the Women's Overseas Service League, and you can certainly expect a lot of them to be patients. Most of those are nurses.

But it is a shame to have these rooms at the veterans hospitals not fully equipped. I want to tell you, when you think about the jobs that these women perform in the service today, you are going to have a lot of them that are going to be injured, a lot of them in blue collar jobs where there are more accidents, and some of the jobs they do today in the service will indicate to you the patients of the future in veterans hospitals.

There are jet engine mechanics, tank turret repair technicians—and, Mr. Chairman, I want you to listen to this, now—they do refueling of aircraft in the air, refuel tankers, fly helicopters and C–141 planes, ferry passengers and cargo to naval air carriers at sea, jump as paratroopers, serve on destroyer and submarine tenders, operate air evacuation teams, and do most of the jobs in the military today, despite the fact that the Army is trying to pull them back all the time.

Thank you very much for having us here, and thank you so much for what you are doing. We certainly support you in this work to improve the hospitals, and we want that permanent advisory bill, H.R. 1137. Thank you so much. [Applause.]

[The prepared statement of Sarah McClendon appears at p. 72.]

Mr. EDGAR. Thank you both very much for your articulate testimony.

Before we move to questions—and we have quite a number for you—I would like to recognize the fact that the chairman of the full Veterans' Affairs Committee is here, the Honorable G. V. "Sonny" Montgomery.

I yield to the chairman.

The CHAIRMAN. Thank you, Mr. Chairman.

I won't violate one of our own rules and try to talk out of order, but I do want to welcome the witnesses and my close and warm friend, Sarah McClendon, one of our great correspondents in Washington and in this Nation.

Mr. Chairman, I commend you on having this hearing today. We have had problems in this area, as has been pointed out this morning. We will look into them and talk to the Veterans' Administration. That is under your jurisdiction and I know you will get something done.

Thank you, sir.

Mr. **Edgar**. Thank you very much.

Before I ask just a couple of questions, I would like to recognize the fact that this subcommittee is the largest subcommittee of the Veterans' Affairs Committee. It has 21 members. Two of those members are women. We are very pleased to have those members as part of this full committee and we believe that many of the newer members will be a great asset to this committee in helping us to focus on the issues relating to Vietnam veterans and also the issues relating to women, and equity, and fairness within the VA.

Sarah, you gave a very articulate statement and talked about the World War I veterans who are women, we know that some women were captured and were prisoners of war at Corregidor——

Mrs. **McClendon**. Over 60, Mr. Chairman.

Mr. **Edgar**. That's correct.

I was wondering, whether or not, with your experience as an advisor to the Department of Defense, whether or not you think that the VA should be prepared in the future to be the primary backup to the Department of Defense, as a medical system in time of war, and to accept women casualties within that system.

Mrs. **McClendon**. Very definitely, sir.

Mr. **Edgar**. I think your statement clearly points out the fact that there are discrepancies within the veterans health care system, particularly here in the Washington metropolitan area, and I think we are going to hear in a few moments of other problems throughout the Nation.

You mentioned in your testimony the need for additional research on women veterans' issues. I have introduced legislation, H.R. 1443, which would extend readjustment counseling services for Vietnam veterans through storefront vet centers for 1 additional year, through September 30, 1985. The legislation also would require the Veterans' Administration to conduct a new survey of the readjustment status of Vietnam era veterans. The study would also call for a definitive analysis of women veterans' readjustment and health care status.

Would you support the provisions of this legislation, and do you think that is the kind of study that would reflect the study that was prepared and you had funded?

Ms. **Van DeVanter**. Yes, Mr. Chairman. Had I not had so much to say in so little time, I had intended to address that very issue. We are aware of H.R. 1443 and are very pleased that the committee is interested in extending the vet center program, not only from the point of view of Vietnam veterans in general, but also from the point of view of women Vietnam veterans especially. Women Vietnam veterans have only recently begun to come into the vet center program, and have only recently begun to come in and get counseling. We feel as though they are very much behind in terms of being able to utilize those services. We feel very strongly, very positively, toward the idea of extending the program. We also feel very positively toward the idea that a request for an examination of the health status, mental and physical, of Vietnam era veterans has specifically finally said that it is going to address female veterans, and that is very important to us. It is, however, only a start.

We feel very strongly that the Veterans' Administration needs to set aside a percentage of its research budget to specifically address research issues on female veterans.

Mr. **Edgar**. Thank you very much.

I would like to yield at this time to my colleague, John Paul Hammerschmidt. He and I serve on the Public Works Committee together and there is an important session of that committee that deals with the jobs bill that is up later today. I would like to yield to him at this moment.

Mr. **Hammerschmidt**. Thank you, Mr. Chairman. I regret that I am going to have to leave for a markup over there, but I did want to thank Miss Van DeVanter and Sarah for their excellent statements.

Sarah, some time when you're in less inhibited circumstances and you're not embarrassed to say what's on your mind, I want you to write us a strong letter so we will really understand. [Laughter.]

Seriously, we do appreciate always your very articulate testimony.

Miss Van DeVanter, I notice that you are sort of like one of our able colleagues, Claude Pepper. He has a prepared statement in front of him but, if you notice, he gives it right out of his head and never looks down. I notice you did your statement that way, so you are thoroughly prepared. We appreciate your comprehensive testimony.

Ms. **Van DeVanter**. Thank you.

Mr. **Hammerschmidt**. I wanted to say that one of our newest Members, and certainly one of our most capable members, Mrs. Johnson, is going to take my Chair. I think it is appropriate that we have a woman over here on the minority side.

Ms. **Van DeVanter**. Thank you, sir. I think that is quite appropriate.

Mr. **Edgar**. Very good.

I should ask Ms. Kaptur to take my Chair. [Laughter.]

I would like to yield at this time to Don Edwards from California.

Mr. **Edwards**. Thank you, Mr. Chairman.

I won't intrude on the committee, except I have one question to ask Mrs. McClendon—incidentally, I thought both your testimonies were first class and have been a great help.

Mrs. McClendon, you were a member of the Defense Advisory Committee on Women in the Services. How did that work? Did that do a good job?

Mrs. **McClendon**. It would do a far better job, but they are very much held back. They make wonderful recommendations every year, and then they submit them to the Department of Defense, which takes them and reads them for 3 months, tries to keep anybody from knowing what they are about, doesn't give them much publicity, and then they recommend back that they can't do this and can't do that. So the Defense Advisory Committee, which I think is about 35 years old—General Marshall started it to help women—they really can't get too far. They could do so much better if they could get some quick action out of the Department of Defense.

Mr. EDWARDS. And you want this committee to do a better job, don't you?

Mrs. MCCLENDON. They do a great job of providing them with banquets and places to go, you know, to meet and all that, but if they would just say "yes" to some of the things we recommended, it would be better.

Mr. EDWARDS. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Would the gentleman yield?

Mr. EDWARDS. Yes.

The CHAIRMAN. Sarah, I meant to ask you, when you were talking to me about how well women have served in the military—and I certainly agree with you—and I am on the Armed Services Committee as are several other members of this committee.

Are you recommending that we put women in combat and use them in combat?

Mrs. MCCLENDON. One of the myths of the United States is that women are not in combat and have not been in combat. That's a total myth. Of course, there are two laws. The Air Force and Navy say women can't be in combat. The Army does not have a law saying that women can't be in combat. The Army goes along saying "We think, we think it is the feeling of Congress that we can't be in combat." Therefore, they try their best to—but women are in combat today. They are in a thing called close combat support, close combat services support I believe it is called. In Germany we had 11,000 women in that status for a long time. We have overall in the Army 20,000 women today, and after their policy review we still have that many.

The Chief of Staff of the Army will admit to you that women are in combat and he will admit to you that women will die in the next war. I don't see how you could keep them out of it because of the fact that, in the first place, you don't know where the front is going to be. You don't know where Russia is going to hit if we have conventional war in Europe.

The CHAIRMAN. Thank you.

Mr. EDGAR. Actually, with modern technology, I guess all of us are only about a half-hour away from the front.

Mrs. MCCLENDON. That's right. Besides, we had better be glad we have trained women because we have got a lot of women in our citizenship and we need for them to be trained ahead of time.

The CHAIRMAN. There is no question that some women are better fighters than men.

Mr. EDGAR. Perhaps with women on the front line, we would have fewer wars.

Ms. VAN DEVANTER. I would like to second what Mrs. McClendon is saying, particularly in the area of the Vietnam War, in which there was no such thing as a front—well, I take that back. There were two zones in Vietnam, combat and noncombat. However, the only noncombat zone was on a map in a tactical officer's desk in Long Binh. Other than that, there was no such thing as a noncombat zone in Vietnam.

Women were killed in Vietnam, women were killed in World War II. Women were maimed and crippled in all of the wars, and this country and this Government has not recognized that. They have tried to pretend that it is not happening because they would like to keep up this pretty front that women are not going to be in combat, and that is simply not true. It dishonors and disrespects the lives that have been given by women throughout the history of this country, and that has got to stop.

Mrs. McClendon. Sir, may I add that we have the names of seven nurses, I believe it is, down here on the Vietnam Memorial now. We lost a couple of nurses at least on the Anzio Beachhead, and we have lost women in nearly all the wars.

When President Reagan went to the Pentagon to speak to the veterans out there about Vietnam, he only mentioned men. Many citizens today will swear to you that there were no women serving in Vietnam. That's a bunch of stuff.

Mr. Edgar. Thank you.

I yield to my colleague, Mrs. Johnson.

Mrs. Johnson. Just very briefly, because I know there are many others interested in testifying this morning that we are anxious to hear.

Miss Van DeVanter, would you tell me, outside of your own personal effort to determine what kind of care is available to women under the verbiage of a fee basis, is there any other study that you know of that has been done in trying to determine the contrast in the relationship between the verbiage that promises such care and the reality?

Ms. Van DeVanter. Outside of my own, there are two things. No. 1, the GAO report, which clearly indicates that that is not happening. However, the Veterans' Administration has said that it conducted a survey following the GAO report in September 1982, at which time they determined that the Veterans' Administration was providing those kinds of care for female veterans.

It seems to me that those two reports are distinctly at odds, and it seems to me that there needs to be an objective evaluation by an agency of the Government which would determine whether or not those things are happening. And not just in the area of GYN care. It is in other areas of medical care, as well as psychological care.

There are numbers of programs in the VA that women are specifically excluded from, that are discussed specifically in the GAO report, and there are others which are not discussed in the GAO report. One of those programs is a special psychiatric treatment program at the Brentwood VA, the new directions program. The new directions program completely excludes females. The nearest program to that program which provides a similar kind of care is 1,500 miles away. That is simply not providing care.

Not only that, the inpatient stress treatment programs for Vietnam veterans, of which there are only four to five, maybe six, as far as we know only one of those programs has ever accepted a female in its treatment program. So clearly there are definitely two different stories that are being discussed. I think it is important to figure out where is the middle ground.

Mrs. JOHNSON. Thank you. That is very important.

I think both your testimonies this morning in regard to the availability of very elemental and routine care for women, which is certainly necessary to retain the maintenance of health for women, This is indeed considered a special service to be attained in a special way. I think that it is a serious problem and one that we will be interested in addressing.

Ms. VAN DEVANTER. There is one thing that I think also should be addressed, and that is that directives coming down from the central office are important. However, whether or not those directives get implemented is of critical importance.

In January 1981, a directive went down from central office to all VAMC's, informing them that on female veterans there are specific exams required as a part of a complete physical exam, and that those exams should be provided and that there should be documentation and monitoring by the VAMC's as to whether or not those things are being done.

The GAO study was done 2 years later. Of all the VAMC's that were evaluated by the GAO, only one had done any monitoring of whether or not those procedures were being done. In that particular facility, they monitored that only 47 percent of the females were receiving a breast exam. Now, that is so clearly simple and obvious that it is beyond comprehension that somebody is not doing a breast exam on an admission. Second only 20 percent of those female patients had received pelvic exams, and third, zero had received Pap smears to evaluate for cervical cancer. That is absolutely unacceptable.

Mrs. JOHNSON. Then what you are saying is that all the right words are on paper?

Ms. VAN DEVANTER. Precisely.

Mrs. JOHNSON. Thank you.

Mr. EDGAR. Thank you.

Mr. Evans.

Mr. EVANS. Miss Van DeVanter, my home State has a Commission on Agent Orange and they have raised a significant question about the coverage and treatment of civilians who served in Vietnam and were exposed to agent orange.

I just wanted for my own understanding, in regard to the number of 7,000 to 8,000 women who served in the military, is that strictly people, in your estimation, that served in the Armed Forces, not counting the civilian women?

Ms. VAN DEVANTER. That is correct.

Now, there are a couple of different things here. The first thing is, nobody knows the actual number of women who served in Vietnam. There have been guesstimates that have been given by Government agencies which have ranged from a low of 559 to a high of 55,000. That is a severe discrepancy. That gives you an indication of how little anybody does know.

We have been given at least some numbers which, according to the Department of Defense, can no longer be readily identified or traced as to where they came from, which indicates that there are probably around 8,000 who served. However, I have also been in contact with someone who is doing research at the center for military history on women who served in Vietnam, and her indication is that there may be as many as 25,000. That is only those who served in the military.

There have also been studies done by some individuals who were involved with the Red Cross, AID, and Department of the Army civilians, who indicate that there may also be as many as 25,000 women who served in civilian capacities in Vietnam. But again, nobody knows, because nobody has ever bothered to ask before.

Mr. EVANS. I would suggest that the VA is saying they don't have enough women to study, that they also look to women who might not technically fall in the status of being veterans but who served hand-in-hand with combat units in a civilian status. I think that could expand the sampling or whatever for the study.

Ms. VAN DEVANTER. That could be appropriate. There could be difficulties legally, though, because of the fact the Veterans' Administration treating people who are not, according to law, permitted to receive treatment by the Veterans Administration.

Our stand on this whole thing is—first of all, they have said there are too few. That is clearly absurd. If they are doing the Ranch Hand Study on 1,200, and doing an identical twin study on what they claim is 400 people—but most likely is going to come out to be about 30 or 40 people—to say that 7,000 people is an insufficient number to do a study on is unacceptable.

Second, those populations are being used because they are special populations; that is, the Ranchhand people handled the stuff directly, and the twins are a special population because one was in Vietnam and one was not. Females are also a special population because the EPA studies have shown that they are more highly susceptible to these reproductive toxic side effects. We have already got numerous anecdotal reports from women veterans who have had birth-defected children, who have had multiple stillbirths, who have had multiple miscarriages, and who have cancers which are unusual in their age groups. Some of these women are already dead. These are women who are 30, 35 years old. These people have got to be studied.

Mr. EVANS. I would agree, and I thank you for that clarification.

Mr. EDGAR. Mr. McEwen.

Mr. MCEWEN. Thank you, Mr. Chairman.

In centering on the question before us, at to service by the Veterans' Administration of our female veteran population, I assure you that you will find strong unanimity on this committee. We are dedicated to responding to the situation you have presented so ably. I compliment you on your testimony.

Having said that, I wish to ask an armed services question following up on the Chairman's question to Mrs. McClendon. The question relates to participation in combat. We were given the history of that this morning.

I would like to know whether or not, if that policy decision were made by the Secretary of the Army, if you would support such a policy in the future, recognizing it has gone on to some degree in the past.

Ms. VAN DEVANTER. Is this a question to me or Mrs. McClendon?

Mr. MCEWEN. Either one of you would be fine.

Ms. VAN DEVANTER. My response would be, if women are going to be in combat, which they already are and already have been, let's at least just admit it and let's not deny the contributions that they are making. They are already there.

Mr. McEWEN. That is what prompts my second question: Is this a good thing, whether or not it has been done in the past?

Ms. VAN DEVANTER. Mr. McEwen, I don't know that it's a good thing that anybody is in combat. My own personal experience——

Mr. McEWEN. That would be my response.

Ms. VAN DEVANTER. My own personal experience in war was a situation which saw what the reality of war is. I mean, my own personal feeling is I would just as soon not see anybody in combat. But anybody who is a citizen of this country owes something to this country for what we have. I am not suggesting that everybody should automatically sign up and become infantry platoon members. What I am suggesting is that everyone, whether you are male or female, owes something back to this country in one way or another, and if an individual is qualified, physically and in whatever other ways are specifically important for that particular job, and wants to take that job, and wants to be in that position, and wants to make that contribution in that manner, then that individual, as a part of their responsibility, has the right to make that particular action in terms of their defense of what they have been given by the liberties which we so really enjoy and which we sometimes so easily forget.

Mrs. McCLENDON. Sir, I think you can't escape it, because I think in about 1990 you're not going to have enough boy babies and grown men of military age to serve and you're going to need all the women you can get.

Also, you can take the histories of our times. We know they served in World War II with Soviet Russia. We know that all of Britain, despite the fact she calls it by some other name, she conscripted and used every man and woman. I think in the next war you're going to use your whole population, old people and young people, everybody.

You do need to know that recently, after their policy review, the Army pulled back women from some obvious jobs where they said they would be killed right off the bat. These were out in front with the Army engineers and out in front in other jobs. But they pulled those back. But there are still women with the Army engineers and there are still women ahead of the guns in Army intelligence. So I think you are going to have to use them because you need them.

Mr. McEWEN. I find your answers most helpful, and I trust you understand the spirit in which the questions were asked. Because this Congress, just 24 months ago, declined to include females in the——

Mrs. McCLENDON. That doesn't mean it was reality.

Mr. McEWEN. That's exactly right. I refer to the registration legislation that was passed in 1980 regarding conscription.

Mrs. McCLENDON. That wasn't reality.

Mr. McEWEN. The Chairman of the Joint Chiefs recently testified that at any given time 10 percent of his female population are pregnant. Is that a factor that should be considered?

Mrs. McCLENDON. That's a fact that should be considered. You should also do what General Vessey, the Chairman of the Joint Chief of Staff, says. It takes two people to make a baby. I don't think they generally consider the fact that these babies come from male and female. They usually say they come from females.

Mr. **McEwen**. Our concern here, of course, is the health of the female population in the military, and later when they are veterans.

Mrs. **McClendon**. Well, it is normal and it is part of the population. I don't think we have faced up to it as a fact of society, that there is 10 percent of them. But that doesn't mean that all of them are. That doesn't mean they can't continue to serve if they would let them for 8 months of that pregnancy.

I think you will find women take off, a.w.o.l.'s and hospitalization and all that, far less than men do. There are a lot more men in the service who are for a.w.o.l.'s, drugs and drinking and disciplinary problems. A lot of these women would like to stay in the service and have their children, and a lot of them marry men in the service.

Mr. **McEwen**. Thank you very much, Mr. Chairman.

Mr. **Edgar**. Mr. McEwen, in light of your questions, just one comment, and then I would like to introduce a witness to you. You didn't ask me the question, but I just thought for the record I would indicate that my personal view is that equal rights bears equal responsibility. I think there are an awful lot of men who don't want to serve and an awful lot of women who would like to serve. I think we ought to have men and women have equal opportunity to pursue the service in all of its aspects, including combat.

But to your latter question, which was important, about women and the problem of pregnancy, I would like to have one of our witnesses come to the table who is a junior vice commander of a VFW post in Philadelphia. She is also probably the only pregnant junior vice commander in the VFW that we have ever had before this committee. But I think she can bring to the witness table—and I will ask her to hold her statement until we have had all the questions to our two panelists.

But let me introduce Norma J. Griffiths-Boris, who served in Vietnam as a nurse and has had a wide experience with the Veterans' Administration medical system. She is well known as a spokesperson for women veterans issues in the Philadelphia area and in the Northeast. We are pleased to have her.

While I have interrupted the questions for a moment, let me ask our other panelists to come forward at this time. We have June Willenz, Executive Director of the American Veterans Committee, a long-time advocate for women's rights in the military and a proponent for equality for women before the Veterans' Administration; Jenny Ann Schnaier, who recently completed her master's thesis at the University of Maryland on the subject of the current readjustment status of women Vietnam veterans. That work is widely recognized as the only review of a specific population available. Also Ruth Young, although not testifying in that capacity, serves as an assistant state director for veterans employment for the State of New York. She is also a member of the New York State Agent Orange Commission. We have invited her to come to the witness table.

Before we hear from you as to your statements, let me, in deference to my colleagues who have not had a chance to ask their opening questions, yield now to Ms. Kaptur.

Ms. KAPTUR. Thank you, Mr. Chairman.

I would like to thank all of the witnesses this morning for coming here, and especially as a new member, you have helped to educate me on the problems of women veterans. It will be a great pleasure to work with you in the years ahead.

I have three brief questions: First, to Mrs. McClendon, I wanted to ask you—you know, this committee is going to be going around the country and visiting different health care facilities over this coming year. I have not yet chosen the areas that I will be going to.

Is there any one facility in the country that you know of that you would identify as exemplary in its ability to serve women veterans?

Mrs. MCCLENDON. As exemplary?

Ms. KAPTUR. Yes. Even one?

Mrs. MCCLENDON. I really don't—I think most of the veterans hospitals are pretty much alike, very uniform. I might add that the construction people who have taken the taxpayers' money to build these places should have been stopped by the Veterans' Administration inspectors because they didn't always include facilities for women's privacy. You might look into that. But I think most of the veterans hospitals are the same.

Maybe some of the other witnesses can give you more help on that.

Ms. VAN DEVANTER. I would not say that there are any facilities which are more exemplary than others, when you speak in terms of the large picture. In other words, I would not say there is a particular VAMC that is more exemplary than others. There may be particular ones that are worse than others.

There are programs within the VA which are better than others at addressing female veterans. There are specific locations within programs which are better at addressing female veterans, primarily because there happens to be people at those particular facilities who are interested in the issue and who may, in fact, be female veterans themselves, who came out of the service and went into the Veterans' Administration because they wanted to continue to work with veterans.

In those kinds of situations, where you have female veterans who are working in those kinds of programs, you very often do have exemplary kinds of situations. But I don't think I would want to take a chance and say that there is a particular VAMC that is any better than another—I mean in terms of the general picture.

Ms. KAPTUR. All right. I would have made it a point to visit that one, if there was a good one.

Mrs. MCCLENDON. If I may point out, ma'am, look at the worst as well as the better. You might want to consult with the doctors who have been organized, doctors who work for the VA. There is a very well-known organization of Veterans Administration doctors. If I were you, I would consult with them.

Ms. VAN DEVANTER. I don't think I would consult with the doctors. [Laughter.] I don't think I would consult with the doctors at all. I think I would consult possibly with the nursing staff. I certainly would not consult with the medical staff. I mean, you're talking about a group who are primarily male, and if you want to know where positive things are happening for females, you don't want to talk to primarily a male population.

I would also talk to groups of women veterans. I would talk to organizations like the Women's Overseas Service League. I would talk to organizations like the Women Veterans' Information Network and those sorts of groups. Those are the people who are going to be able to give you more information. No offense, Sarah, but I don't think I would ask the doctors.

Mrs. McClendon. I think you have made a good point, a very good point.

The doctors that I am talking about are not doctors who agree with the Veterans' Administration. They disagree about what care they are giving all veterans.

Ms. Kaptur. Thank you.

I wanted to ask Ms. Van DeVanter, how would you go about determining the number of female veterans? It sounds like you have done some of your own work in that area and have become frustrated. How would you suggest that the Government go about ascertaining that number?

Ms. Van DeVanter. The only way that this is ever going to happen is when for some other reason—and I have absolutely no illusions that it is going to happen because somebody wants to know information about female veterans—but when somebody goes through St. Louis and takes all of those records that are in files and puts them into the computer.

The problem is that the Defense Manpower Data Center did not come on line, was not authorized by Congress until the early seventies, didn't come on line until 1970, 1971, so that all the information which is available about veterans that is in their files didn't begin to get put into the computer until around that time. Anything prior to that time is not on computer. So the only way it is going to happen is if somebody goes through those millions and millions of records and begins to put them into the computer, where you can then plug into the computer and pull out information.

But you are still going to have a problem, in that during the late years of the Vietnam war there was a major effort on the part of the military to purge all military records of references to race or sex. That is going to put a severe damper on your ability to ever get that information.

Ms. Kaptur. Thank you.

My third question relates to the GAO report, which recommends that we explore various ways to offer alternative health services, alternative care, if a VA facility cannot perform a service.

What do you think of that recommendation as opposed to having the VA perform services as they do for men?

Mrs. McClendon. I have already said that I am very much opposed to alternative services. I think they should give the full service in the hospitals. We're entitled to it. We're citizens.

Ms. Van DeVanter. My concern about that is, if there is not a sufficient population of female veterans to warrant someone who is a qualified individual to handle that particular area—and obviously we're speaking about the area of gynecology here—if you don't have a large enough population to support somebody who wants to work in a hospital, who wants to work with patients, who wants to deal with those issues, then the chances are that you're going to end up with what happens in many cases in the VAMC's—somebody who is an 80-year-old retired physician, who is there because he can't hack it any more in private practice, and he is not going to be up-to-snuff on skills and he is not going to be up-to-snuff on doing proper patient cares and dealing with diagnostic and making diagnoses.

My feeling would be that if you have the population within a VAMC to support having somebody on staff who is a fully qualified gynecologist, fine. But I think you can't make specific straight regulations down the line and say this is the way it is always going to be in every VAMC.

I think you have to take into consideration what happens on a local level. If you have a smaller clinic or a smaller VAMC, and that particular VAMC or clinic is affiliated with a medical school or teaching hospital, let's utilize the possibility of having someone on an oncall basis, utilize the possibility of having somebody there who is on contract, who comes in maybe 1 or 2 days a week to deal with the gynocology clinic situation, or who comes in when a female is admitted with a problem that may be a secondary problem, a gynocology problem, call that person in on a consult.

It is done in the private sector. If you have a situation where you have a small community hospital and you don't happen to have a neurosurgeon on staff at that hospital, if you have a patient who has a neurosurgical problem, you call in a physician who is a neurosurgeon on consult. I don't see any reason why that couldn't be done within the VAMC.

I recommended three areas. No. 1, contract fee for service, which is supposed to be happening but, in reality, is not. So we need to deal with the issue of whether or not contract fee is actually occurring, making sure the information gets out to those women that they are entitled to contract fee. But if they are not service-connected with a gynocology problem, they can't get contract fee. That's the way the laws read.

The second recommendation was the idea of having somebody on an oncall basis——

Mr. **Edgar**. Would the gentlewoman yield for just a moment? I know you're on No. 2 and I will remember that.

I would like to just announce to the Members that a vote is pending on the House floor on approval of the journal. For freshmen members and in keeping their attendance, it is important for them to go and vote on it. I am sure the journal will pass without my vote, so I am going to skip running over to vote.

If some would like to go now and come back, I will be glad to recognize you as soon as you get back. I am going to yield, after Ms. Kaptur is completed, to Mr. Bilirakis.

Also, I would like to say we will go through the course of the witnesses right through this morning, except for substantive votes that take place.

I yield back, and I appreciate your yielding. If you could summarize quickly those two points, then I can yield to our colleague and we can proceed.

Ms. **Van DeVanter**. The second would be pulling somebody in on consult.

The third would be utilizing DOD facilities which may be available in the area, because most Army, Navy, and Air Force hospitals do have good gynocology departments because they not only have a fairly substantial contingent of female service members but they also have to treat, by law, the family members of male service members. So in most cases they do have good gynocology departments.

Ms. **Kaptur**. Thank you very much.

Mr. **Edgar**. Thank you.

Mr. Bilirakis.

Mr. **Bilirakis**. Thank you, Mr. Chairman.

Just a couple of very quick statements, I suppose, and then maybe a quick question.

I served with women some 30 years ago in the service, and I will tell you that the jobs they did they did well. I am certainly convinced of that. I will admit to the same sort of ignorance that apparently exists, and that is I have never really given it any thought. I, thank God, haven't had to use veterans facilities myself, but I have visited them often. I have volunteered down in Tampa quite often, pushing wheelchairs around and that sort of thing. I have never really given any thought to women's facilities. I certainly admit ignorance there and I have learned an awful lot here today. You two have done a splendid job.

I am also very pleased that you have recommended specific options. We hear the needs up here so very often, but very seldom do we get the recommendations on how to address those needs except for the more dollars type of a thing. But we have received specific recommended options from you and I commend you for that.

I do find it amazing that we can't determine how many women served in Vietnam, with our computer system as it is, or at least as it should be.

I would ask one question, more curiosity than anything else. I am an engineer as well as being an attorney, and I know about all the certification of plans and specifications that are ordinarily required before you go into any sort of construction. I ask the question—and maybe it doesn't require an immediate answer—but I ask the question for the record, at least, isn't there some sort of certification of plans and specifications that was required before we went into the building of these veterans medical facilities which would have addressed this particular problem of the women?

Ms. **Van DeVanter**. One would think so, Mr. Bilirakis, and one would hope so. However, I think that probably the more appropriate people to ask would not be the members of this particular panel but might possibly be the members of the Veterans' Administration panel.

Mr. **Bilirakis**. I would ask that question for the record, sir. Maybe we can find out through the VA.

Mr. **Edgar**. I hope that you can return, and the VA will certainly be here later and we will ask that question of them.

Mr. Bilirakis. I certainly will.

Mr. Edgar. Thank you for staying.

Mr. Bilirakis. Thank you so much for your very fine testimony.

Mr. Edgar. Even though members have had to run for the vote that is being cast, the statements that you were about to make will be made a part of the record and reviewed by those members. They will be back to ask some specific questions. Your statements are up here before them.

Mr. Edgar. I would like now to turn to the other panelists that we have. I would ask, just as a matter of respect, in terms of time, if we could have all of your statements appear as part of the record, ask you to summarize as much as possible, and each of you take approximately 5 minutes, if you could.

Our first witness on this panel will be Ms. June Willenz, executive director of the American Veterans Committee. It is nice to have you here today.

STATEMENTS OF JUNE A. WILLENZ, EXECUTIVE DIRECTOR, AMERICAN VETERANS COMMITTEE; JENNY ANN SCHNAIER; RUTH L. YOUNG, MEMBER, NEW YORK STATE TEMPORARY COMMISSION ON DIOXIN EXPOSURE; AND NORMA J. GRIFFITHS-BORIS, JUNIOR VICE COMMANDER, VIETNAM VETERANS ASSISTANCE POST, VFW POST 28, PHILADELPHIA, PA.

STATEMENT OF JUNE A. WILLENZ

Ms. Willenz. Thank you, Mr. Chairman.

I am very pleased to be here today, and I will try to summarize the statement and summarize the position of the American Veterans Committee.

I have been the executive director of AVC for the last 18 years. I would like to commend you and Congressman Edwards for placing this legislation before us and for showing your commitment to the interests and needs of women veterans.

In my capacity as executive director over the years, I have noticed that there have been no data, no statistics, no studies, no research, that came across my desk that indicated women veterans existed. They have been a forgotten population. In 1977 there was a National Academy of Science study which studied the hospital system of the VA. That particular study was male-based. The VA response to that study also excluded women. This neglect has been attested to by the other witnesses. This has characterized all the studies, the reports, et cetera, not only in the public sector but also in the private sector. There has been no social science research.

Now, over the years also I have had occasion to speak to a lot of women veterans, and I have heard from women veterans. They corroborate not only what the witnesses have said but the evidence that was pulled together by the GAO, which was very, very welcome. We suggested as a result of what we had been finding that it would be very useful—in fact, it would be essential—to have an Advisery Committee on Women Veterans. I have been sitting in on meetings of the DACOWITS for some years, and I noted that the concerns and the interests of women in the military were being advocated, they were being addressed and they were being brought to the attention of the Secretary of Defense. There is no such vehicle in the VA. Not only were the facts about women veterans not being reported and there was no interest in them, but the fact was there was no agency within the VA that was looking after their interest.

So, in the midseventies we suggested to the VA Administrator that an Advisory Committee on Women Veterans would not only serve the interest of women veterans, it would serve the interest of the Administrator. He would have the input, he would have the advice and counsel of an independent citizens' body, and he would also have the input and the channel for women veterans to express their concern.

Now, I don't see any contradiction with the fact that our present Administrator, Mr. Walters—and I want to commend him for that—has indicated an intent to set up such an advisory committee. We applaud him for that. We went through two previous Administrations and did not obtain that commitment. So we are delighted that it is occurring.

However, we think that the consent of Congress would be very important, to actually have the backing of the Congress, for this purpose. It would give it more credibility; it would provide a kind of oversight; and it would certainly convince women veterans that they are finally being remembered; that they, too, made their contributions to the defense of the Nation and they served in wartime. As we have heard, they suffered casualties; they suffered injuries; and they gave their all. They were true volunteers. Not one of them was drafted. We know that. So we see no inconsistency.

We would like to see a statutory requirement that there be an Advisery Committee on Women at the Veterans' Administration. We do not think it will hamper the Administrator at all. We think it would give the Administrator the flexibility he needs, and it would also mean it has to be on the record and that there would have to be reports. Therefore, women veterans would be convinced that, indeed, their interests are being looked after. So we are delighted at his actions and we would hope that this subcommittee would report it out favorably to Congress, and that it be enacted.

Now, I want to just mention that we can't undo the past. We cannot undo the neglect and we cannot undo the omission as far as women veterans are concerned. But we must be concerned about the future. There is a demographic challenge ahead for the VA that concerns women as much as men. There is an aging population of veterans who served in World War II. Right now, the major group of women veterans are World War II. They are going to be turning 65. They are going to be have the same needs, plus additional needs, as male veterans. There is a challenge ahead as far as long-term care, ambulatory care, acute care services, and domiciliary care.

In order to have the planning that is necessary—and we know that the old facilities have not been geared for women veterans—we need to have not only the planning for the new facilities that are going to be built, but we need the remodeling and the renovation, and we need a commitment of resources. We never see anything in the VA budget that is specifically geared to renovation or anything like that.

Just to conclude, very briefly, the fact is that the GAO report has presented us with a set of facts. They are not totally all inclusive, but they are enough and they are corroborated by the testimony of hundreds and hundreds of women. Now we have the VA commitment. We have new actions by the VA and we want to see them continued. I can assure you that from the private sector you will get our cooperation. Now is the time to make the challenge to meet the challenge. Now is the time to commit resources; otherwise, our challenge will not be met.

Thank you.

[The statement of June Willenz appears at p. 74.]

Mr. **Edgar.** Thank you very much.

You appended to your statement some correspondence and, without objection, that will be made a part of the record at this time.[1]

Our next witness will be Jenny Ann Schnaier, who recently completed the master's study on this issue. We are pleased to have you here.

Your full statement will be made a part of the record, if you could summarize.

STATEMENT OF JENNY ANN SCHNAIER

Ms. **Schnaier.** Mr. Chairman, members of the committee, it is a great honor to be here.

As you have said, this research was completed for my master's thesis at the Univerity of Maryland, and I think, as far as we all know, it is the first completed research study on women veterans. What my testimony will speak to today is the results of that research.

I have brought with me a copy of my entire project, not to be submitted into the record, but just for your own interest, so that you can read a little more about it.

Mr. **Edgar.** Can the committee have access to that?

Ms. **Schnaier.** Yes.

Mr. **Edgar.** We will make it a part of the file of the committee proceedings, as opposed to being part of the full record.

Ms. **Schnaier.** Thank you.

I will skip over some of the background because I believe you have heard that. People here today have talked about the fact that we don't know how many women served during the Vietnam era, we don't know very much about them, and that there have been no studies that have assessed what their problems are. I will go directly into talking about what my research was. Its intention was to find out about the mental health problems that women Vietnam veterans might be having, and to try to find out if what we are hearing about from a few vocal women are just very singular problems or whether they are problems for women veterans as a whole.

For my study I used a written questionnaire that was given to approximately 90 women across the country. It asked about background information, about their experiences in Vietnam, about their problems today, and about some of their feelings. One of the first things that came to my attention was that we had a return rate of 97 percent, which showed to us that there was a great need for people to talk about their experiences.

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[1] See p. 78.

What I am going to do now is to skip directly to some of the conclusions that I found in this research, because I think that is what you might find most helpful.

The first conclusion that I reached was that my research provided preliminary evidence that posttraumatic stress disorder [PTSD], may be applicable to the experiences of women Vietnam veterans. The instrument I used was found to be reliable and valid, plus showed that approximately one-third of the posttraumatic stress disorder symptoms were identified by 25 percent or more of the subjects as presently occurring between 10 and 30 times a month. Those symptoms are what represent a fairly complete picture of PTSD as defined by the American Psychiatric Association, the same kinds of psychological symptoms that we know some male veterans are suffering from.

Second, I specifically found mental health distress among the sample that I looked at, and I will read you some of those statistics—27.6 percent reported having suicidal thoughts between 1 and 9 times a month; 19.5 percent reported feeling alienated from other people between 15 and 30 times a month; 19.2 percent reported feeling depressed between 15 and 30 times a month; 16.1 percent reported feeling an inability to be close to someone they care about between 15 and 30 times a month; and 10.3 percent reported feeling numb or nothing inside between 15 and 30 times a month.

These are just a few examples of what I am calling a significant minority of these women that are suffering. Those problems just discussed are the kinds of symptoms that have been associated with male Vietnam veterans in past research.

A third conclusion that I reached was that there were also some positive, growthful aspects that came out of the Vietnam exerience. I think that is an area that is not really addressed for male or female veterans. A lot of women cited both professional and personal gains came out of their strength of surviving their Vietnam experience. In the responses that I got, the women spoke about wanting that positive part to become public as well. They want people to know that they gained something, and that they have positive thoughts about that time. I also think that to play up that role would be important for women veterans so that they, like male veterans, can hold their head high and talk about their experiences. I think it would help the community and the veterans themselves to come to terms with their experiences.

The final conclusion that I reached was that as far as my study showed, women veterans were pretty different from male veterans, at least as far as background information is concerned—their age, race, education—lots of things that really serve as a caution, to be careful not to make certain assumptions about them based on what we know about men. We can use the male veterans information as a guideline for us, but we should be careful not to jump too far in our conclusions about that.

I would like to speak now about what is important about these findings and how can they be used.

Obviously, as the first research study, it serves as a focus for further studies. My study collected a lot of different information, a great deal of which I couldn't even begin to use yet because there was so much. I think that will serve to help mental health professionals, commissions, and legislators in understanding how to guide future efforts and looking into the area.

I also think that we need to be aware of the fact that in these women I studied minds, 65 percent reported feeling a strong cynicism about Government, processes and agencies, something that we already know male veterans have reported.

Another interesting fact was that approximately 50 percent of the women in my sample had sought counseling at some time since returning from Vietnam. Greater than half of them never discussed their experiences in Vietnam with their counselors. Now, we can't really be sure what the reason is, but obviously they are going for professional help because they are having some problems and they are neglecting to discuss Vietnam, or perhaps people are neglecting to elicit what kind of experiences they had.

I also feel that it provides some programmatic and counseling implications because of the mental health distress that is seen in what I am calling a significant minority. For those people who reported having symptoms since homecoming approximately 10 or 13 years ago, 70 percent of those women still say they have problems today. That is a long time to be experiencing distress.

The fact that there was a 97 percent return rate mean these women really want to be heard. They want to tell their story. My questionnaire was 12 pages long, and on almost every single response I got extra pages that were handwritten to me because there was such an outpouring of their experiences. I think it is very difficult to neglect this kind of outcalling.

Plus, as some other people have talked about, we have to start thinking towards the future and preventative measures that can be taken. There will be more women in the military in the future and preventative measures that can be taken as far as mental health and physical health will be saving us money and time and saving the distress that women might eventually go through.

Finally, I would just say that my research serves as an indicator to be careful how we view women veterans, not to make too many assumptions about them, not to ignore them, but to use the research on male veterans as guidelines to help future research and to keep an open mind when thinking about what areas we might still need to address or we may have totally missed in our typical thinking about veterans in general.

I thank you for your attention.

[The statement of Jenny Ann Schnaier appears at p. 80.]

Mr. **Edgar**. Thank you for your great conclusions. Obviously, they have been backed up by a great deal of research and we appreciate your contribution this morning.

Our next witness will be Ruth Young, who is a member of the New York State Agent Orange Commission. Ruth, we are pleased that you came to Washington for this meeting, and your full statement will be made part of the record. We would appreciate it if you could summarize.

STATEMENT OF RUTH L. YOUNG

Ms. YOUNG. Thank you, Congressman Edgar and members of the subcommittee, for inviting me today to give testimony on behalf of the Advisory Committee on Women Veterans.

I would also like to apologize and state that I will not be able to give scientific facts and background because I just had the opportunity last night to read the GAO report and I just recently received the invitation to testify, so I haven't been able to get a great deal of information together.

However, in spite of just reading the GAO report last night and becoming indoctrinated with what I'm talking about today, I realize that my statement, which was prepared Sunday, somewhat covers many of the areas that are outlined in the report, so I was glad of that.

I would like to mention briefly that I am a veteran of the Vietnam era, having served in France and Germany. I am also a Federal employee, having spent 19 years with the Federal Government. My employment in the Federal Government has been 3 years in the Army, 7 years with the U.S. Postal Service, and 9 years with the Labor Department.

I allude to mostly personal experiences in my statement, one of which having been a positive experience that I had with the VA hospital in Manhattan, N.Y. After reading my statement—and I don't want to read it again here—you may wonder why, as a Federal employee, during the time I was hospitalized, why I did go to the VA hospital. I wanted to elaborate on that a little bit.

I found myself in a situation years ago in 1969 when I was not at the salary grade level I am at now. In 1969, if I am not mistaken, most health insurances, or at least the one I was participating in, did not provide for total coverage, especially anesthesiology. This made it difficult for individuals such as myself to defray the costs of the additional medical services that would be required to have an operation. Therefore, after looking at what my medical insurance would pay and what I had on hand, I realized that I could not have this operation in the private sector. Thus, I decided to go to a VA hospital. The doctor diagnosed that I had to have a tonsillectomy which they performed shortly thereafter.

Subsequent to that, in 1979, I again found myself in a situation of having to go to a VA hospital, this time for a different reason all together. I am basically a person that hates to go to the hospital. If it was not for the fact that I was seriously ill or I thought it was time for me to go, I would not have gone. I was out in the field working because, as Assistant State Director, I am required to go where my supervisors say I have to go at any time in New York State or, if necessary, to go out of the State. I was working in Brooklyn with a veterans organization. On my way driving back to my area of jurisdiction I passed out in my car.

Now, it just so happened I was not going real fast. I realized that I had blacked out, pulled over to the side and I decided I had better go to the nearest hospital. So I went to the VA hospital, Fort Hamilton, Brooklyn, N.Y.

After going to this hospital, I wished I had not gone at all because I received what I considered to be insensitive and callous treatment. Because I am a single woman, and because the doctor diagnosed that I was pregnant, in addition to being untreated, I was made to feel promiscuous even though I indicated to the doctor that I knew, unless it was by osmosis, that I was not pregnant.

In addition to being embarrassed in front of other individuals, along with the physical problems I was having, I felt mental and psychological problems evolving as a result of this experience. So I said to myself the best thing for me to do is to get out of here. I went to another VA hospital and was given a diagnosis, which I don't remember exactly, but it was along the same line, pregnancy. I was mailed an appointment to see the visiting gynecologist, I guess the staff person the hospital was contracting with on a fee basis to cover these problems.

When I got the notice in the mail that I would have to appear 4 months later, I called the hospital and found out this was the earliest appointment I could get. Subsequent to that appointment, with the pain and discomfort I was having, I secured a private gynecologist. As a result, I experienced a partial hysterectomy in 1981. I had a hernia at that time also, which was repaired.

My prime concern here is that I would not like this situation to happen to another female veteran. I don't expect, just because I am a veteran, having served in the Vietnam era, or in any era, that I should be entitled to special privileges. However, when emergency situations arise—either because I don't have the funds or because of some other reason, I feel I should be entitled, along with other women veterans, to be afforded appropriate and timely care.

In addition to that, I would like to say one last thing, that in all the years I have visited the VA hospitals on a personal basis, I have never had a complete medical examination. If it has been for my throat, someone has looked at my throat. If it has been for my ear, someone looks at your ear. I think this is horrendous.

Last, I denoted one personal experience in my testimony of a female veteran who was service-connected disabled that was referred to me by the chairman of Veterans' Affairs of the Suffolk County Legislature. I guess as a last resort he contacted me, even though I was not the person that could provide the proper supportive care to this individual. The fact that I am an assistant State director for Veterans employment implies many things to many different people, that I am encompassing a lot of areas or that I work for the VA, which I do not. As a result of contacting this service-connected disabled veteran, most of her immediate problems were brought about by the fact that she had taken sick leave from her previous employer, had been terminated because of excessive leave, and finding herself in a position of not having income to support herself while she was in the hospital and thereafter, once she came out.

Additionally, the doctor from the VA hospital would not release her because of her medical problems; thus, she was ineligible for unemployment compensation insurance because that law says you have to be ready, able and willing to work. Then she was ineligible for Social Security benefits for some additional reason becase of law. So the only income this woman had was the 30 percent service-connected disability compensation that she had coming in.

The only way I could see to resolve this situation at that particular time was to contact the coordinator from the forgotten warrior project of Disabled American Veterans who had recently established an office in Nassau County, N.Y. I referred her case to him. He was able to work with the Veterans' Administration in terms of trying to get her disability upgraded, while additionally trying to reestablish some type of relationship with the Social Security Administration so that she could get Social Security benefits.

In addition to not providing appropriate medical services to female veterans in many instances, the supportive services were not there. Many individuals, including myself, are not totally familiar with all of the requirements of all agencies. Thus, I was just taking a chance that I was providing this particular woman with the proper services. It would seem that these services should be provided on the premises of all VA hospitals.

Mr. **Edgar**. Miss Young, we do have other witnesses. I want to say that your statement has so many good personal illustrations of the inhumanity that you and others have experienced with the VA facility that I let you go a little over your 5-minute period.

If you could summarize in 30 seconds or a minute or so, it would be helpful. We have a whole panel of other witnesses and I want to make sure we adequately have time for questions.

Ms. **Young**. Thank you, Congressman Edgar.

In summation, I would just like to say that I hope my statement does not reflect negatively upon all VA medical facilities and the staff that do provide and insure appropriate and adequate medical care and support services to their veteran population, including female veterans. However, I do feel that establishment in the Veterans' Administration of an Advisory Committee on Women Veterans will insure that regulations and standards promulgated by the President, Congress, and VA Administrator, will be alive and consistent in all VA medical facilities, and provide female veterans the good feelings of sisterhood brought about as a result of their service to their Government and their country.

Thank you, Mr. Chairman, and members of the subcommittee.

[The statement of Ruth Young appears at p. 83.]

Mr. **Edgar**. Thank you very much for your complete statement and for your personal experiences.

I introduced Norma Griffiths-Boris in kind of an unusual way. We welcome you here today. We are pleased to have you as part of our panel. Your full statement will be made a part of the record and we appreciate the fact that you're not only here but you are wearing your VFW hat.

You may proceed as you wish.

STATEMENT OF NORMA J. GRIFFITHS-BORIS

Mrs. **Griffiths-Boris**. Thank you.

Mr. Chairman, members of the House Subcommittee on Hospitals and Health Care, I would like to express my honor at being invited to testify before you today.

I am Norma Griffiths-Boris. I hold membership in many veterans organizations, including life membership in the DAV. But today I speak as an active member and as junior vice commander of the

Vietnam Veterans Assistance Post of the Veterans of Foreign Wars in Philadelphia.

I served my country for 5 years and 7 months in the Army Nurse Corps, 1 of those years as a triage nurse at an evacuation hospital in Qui Nhon, Vietnam. I met many goals during my career and I attained the rank of captain in the service.

Two years after my return from Vietnam I had a severe mental breakdown. That ended my career in the Army with a medical discharge and a 30-percent disability retirement. The details of my treatment in military, civilian, and finally, now, the VA facilities, from my discharge until today, are summarized in my written testimony.

Unfortunately, before I was able to confront my feelings about Vietnam and about my rejection since my return from Vietnam, I remained one of those anxious, depressed, withdrawn women described in those records. I was a diagnosed and am a diagnosed schizophrenic. That is a woman that you do not see today.

That work began 11 months ago and still continues, but I have had to define my problem all along the way. Even the men in the outreach don't want to hear my war stories. They never tell of victory or glory; only of sadness and of bore, and of tears never shed in Vietnam or since. The rap group falls silent as I talk about carnage, and there is no comment, no response. I needed someone with a special understanding of this experience who could at least listen and respond. This is the reality of a woman, a former nurse, trying to get help for post-traumatic stress disorder.

In a 2-week hospitalization at the VA hospital in Philadelphia last June, I had to remind my doctor at every session that I had served in Vietnam. Despite that obstacle, I obtained the control I needed to return to my VA outpatient therapist, where I was gaining ground. We have progressed.

My need to define myself as a veteran as eligible, and even as a victim of PTSD, has repeatedly provided insight as well as frustration. Of the few inpatient programs treating PTSD in the VA, only one has admitted a woman that I know of. These facilities are not available elsewhere. Though post-traumatic stress disorder has become an established diagnosis for the men, it is not often considered when dealing with a psychologically disabled female veteran. Research is sparse. Ignoring the problem continues.

Bringing in experts to define the problem is not necessary and is time consuming. Many experts sit before you. We have written about aspects of PTSD revealed by but not confined to women, who seem to deal with this problem in feelings rather than in simply recounting an experience.

Many problems of being a female are cited in my written testimony. These cannot even be approached until there is some input by the women experiencing these problems.

I come with a letter from my VFW Post No. 28 recommending rapid approval of House Resolution 1137 establishing a VA Advisory Committee on Women Veterans. The VA has now recognized this need. I must, however, address one aspect, and that is that Veterans Administrations change. If the committee is not established permanently by Congress, its existence, too, will change.

The well-meaning of individuals has kept us on the outside of veterans issues for years. The response of the last Administrator to the GAO report that was discussed here today was positive. In his reponse, Mr. Nimmo proposed many programs of study. I could not find any information that any had been implemented since his resignation or before. I want to be able to call the VA Central Office and contact someone who is aware of the problems facing female veterans and of ways of dealing with them. Misinformation is rampant in the VA according to medical care and benefits to both men and women. The unique needs of women are not known by anyone except the women who have them. This is not now possible and needs to be established.

There are many suggestions today that I could reiterate, but it isn't necessary. There are many experts on treating post-traumatic stress disorder. My poetry is used as a training tool for nurses working on the inpatient unit at Coatsville. There is a lot of knowledge about the uniqueness of women veterans' needs. Putting this together with established facilities is all that is needed, and that is where we need your help.

Thank you.

[The statement of Norma Griffiths-Boris appears at p. 84.]

Mr. **Edgar**. Thank you very much, Norma.

I would like to recognize the other members of VFW Post 28 from Philadelphia who are here. I wish they would stand at this time. Thank you for coming and helping.

I know that other members of that post and other members of the support community in Philadelphia have been very supportive of the efforts that you have made, Norma, in your area.

All of you have provided outstanding testimony to get the message not only to this committee but to the Congress of the United States on the need to be more fair, more equitable, as it relates to having policies that deal with women and care about the specific needs and concerns of women. Equal rights and constitutional amendments dealing with equal rights may take some time, unfortunately, but there is no reason that we should wait any longer in terms of having equal and fair rights for you within the VA system. I want to congratulate all of your for your statements. They are brought with articulation and also with a great deal of feeling.

One question that came to my mind—and perhaps, Ms. Willenz, you might want to respond to this, or others—and that is, is it also time for the established veterans organizations to have an advisory council made up of women veterans, or do the traditional veterans organizations meet the needs of women across the country, and what improvements might they also make in helping to be a vocal voice to sensitize the Members of Congress and State legislators as to the needs of veterans?

Ms. **Willenz**. Thank you, Mr. Chairman. I feel that I can only really speak for my own organization, perhaps with some suggestions for the others.

I think that women veterans have only sporadically been organized. They have joined a number of organizations—the VFW, the American Legion, the VVA, the American Veterans Committee, Disabled American Veterans, and AMVETS. They have not been a strong voice in those organizations. They have probably been quite overwhelmed by the majority of male veterans in the organization, and I have had reports that they have not been always welcome in those organizations—at least in the early days after World War II. I believe the situation has changed. I know there are some all-female posts in some of the organizations.

I think an advisory council of women veterans in an organizational sense would be an excellent idea and would be a counterpart to the advisory committee that we hope to see in the Veterans' Administration. I would like to pledge my own organization to cooperate thoroughly in trying to set up such a council. I think it would be very worthwhile because there are no women veterans organizations with strong, powerful voices in Washington. There is a WAC veterans organization, there are some ad hoc groups, there is the Women Overseas League, et cetera, but they have not really taken a firm political hold.

Now that their interests are finally being publicly aired, and with the hope of commitment from the VA and the Congress, it is time that the women veterans stepped forward and declared themselves a political force.

Mr. **Edgar**. Thank you.

Would any of our other panelists like to respond to that question?

Ms. **Van DeVanter**. I will just quickly note that Vietnam Veterans of America established the women veterans project in 1979 and we have had a steering committee on the women veterans project for quite some time.

I agree with the suggestion that it would be appropriate for the traditional veterans organizations to have such steering committees or advisory committees. Especially in service organizations where there have been very few female veterans in the past, I think it might assist them in doing a little bit of consciousness raising. But I think it would be appropriate because it is important to have the input of all of the veterans service organizations to the Congress on any issues which affects veterans, no matter who the veterans are, whether they are minority veterans, disabled veterans, women veterans, whoever. I think it would be appropriate to have such groups in the organization who can connect and relate with the Congress on issues of this kind of importance, as well as with the Veterans' Administration.

Mr. **Edgar**. Thank you very much.

Mr. Richardson, do you have any questions at this time?

Mr. **Richardson**. Mr. Chairman, I apologize for being late.

I want to commend you for having convened this hearing and I would like to be added as a cosponsor to your bill. I think it is a much-needed piece of legislation.

I am going to ask just one question, and it may have been covered in earlier testimony. I notice on page 4 of the statement of the American Veterans Committee, that Mr. Walters has said he is going to establish such an advisory committee. I wondered if the panelists felt—Has this been implemented at all? Has Mr. Walters convened such a committee?

Mrs. **McClendon**. No, sir. He has asked several of us about it and I know June Willenz and I have talked to him. He has asked quite a few people to give him names of people who would be good to serve, and he has asked Mrs. Dole to make recommendations.

I think that is very good. I commend Mr. Walters for his activities and his interest, and also I commend him for his promises which he made to me when I heard he was going to be nominated. He promised me that he would take care and look after the interests of women and would be more considerate than people had been in the past. I commend him for all that.

But I think he needs a helping hand. He needs your strong legislation here to make this thing permanent.

Ms. WILLENZ. I would like to second what Sarah has said. Administrator Walters did tell a delegation from the American Veterans Committee that he would set that up. As I indicated in my testimony, there is a long history. We had been suggesting this for the last 6 or 7 years to the VA, and we also brought it to the attention of the Congress and to some of the members of this committee. I think this is one of the reasons that we have this legislation before us.

We think Mr. Walters means what he says. He has appointed an assistant to deal especially with the needs of women. He has someone on board in the Department of Medicine and Surgery who is coordinating. But like Sarah, I would like to say I think it would enhance the prestige of such a committee, it would provide a more credible channel, if the Congress also put its stamp of approval and enacted this legislation so that it would become statutory. We have the commitment of Mr. Walters, but we do not know who his successor will be. We want to see a continuing concern. Women veterans are not going to go away. There are more of them. In fact, as has been pointed out, the population of women veterans is increasing.

May I mention also that it is a younger population and that is another demographic challenge. We have more and more young women going into the military, and even though the present administration has put a damper on it, I don't think that is going to hold.

Thank you.

Mrs. MCCLENDON. Sir, I don't think we told you before that there are 180,000 women on active duty all the time now, in all the services. The Reagan administration says they plan to increase that to 210,000, so that will give you an indication that you're going to have more and more women veterans.

Ms. VAN DEVANTER. I will briefly mention, Mr. Richardson, that Vietnam Veterans of America also supports the concept of congressional legislation supporting the advisery committee. We also have a long history with the Veterans' Administration Administrators. We have been through three different Administrators and five different answers over the space of the last several years in terms of establishing this committee. We have met with Mr. Walters and he has assured us he is going to establish the committee and we feel quite confident that he is going to do that. We are very pleased by that. We are very pleased by his appointment of Dr. Kinzer in the position of Special Assistant to the Administrator in dealing with women veterans. We are quite pleased with the actions that Mr. Walters has taken.

However, we are concerned about the future vagaries of political appointees who will be in that position and we don't want to have to come back again in 2 or 6 years when there is a new Administrator and start all over again if that particular Administrator decides that he doesn't think it is important to have an advisery committee.

Mr. RICHARDSON. I would just like to state, in just reviewing one testimony here, that according to the census we have 4 percent of the veteran population being women. That strikes me as statistically incomprehensible. In the course of my travels throughout my district in New Mexico, I come across many women who have been veterans who don't know that they could have applied for some kind of benefit.

I would just urge that in the appointment of this committee, Mr Chairman—and I notice you have given designations to a number of people, the Secretary of Defense, et cetera—that we not forget women from minority groups. The reason I say this is that I come from a district that is 40 percent Hispanic and 20 percent native American, and also a district that proportionately has a very high veterans population. I would hope that in the course of appointing, whether it be members of the advisery committee that Mr. Walters appoints, or the one that Chairman Edgar comes across, that Hispanic women and Indian women and black women, minority women not be forgotten.

I must stress again the Vietnam veterans. Talk about being forgotten, talk about being neglected in budgets and in attention and recognition, that this country has given others and not them, that we not forget those that have done so much but have been forgotten.

I just would like to endorse this resolution, Mr. Chairman. You are always leading us in a number of areas and I would like to add my name as a cosponsor.

Mr. EDGAR. Thank you very much. I appreciate the gentleman's comments. I want to work with the gentleman to make sure that not only the legislation itself but the report that accompanies the legislation when it goes to the floor takes into account the minorities that you have suggested. I think that with our consideration and concern for women's issues, that we also have to be concerned with the minority questions.

Are there additional questions of this panel?

Let me make two comments. First, there may be additional questions submitted by Members who had to leave for votes that will be submitted for the record. I ask unanimous consent that they be allowed to proceed in raising those questions.

Mr. EDWARDS. Mr. Chairman, I wanted to make one comment.

I don't think I have ever had the pleasure of listening to a better panel and a more articulate group of witnesses. I am very grateful.

Mr. EDGAR. Let me finally close with this comment.

Teddy Roosevelt once spoke out strongly in support of the obligation to men of his day who had served in defense of this country. While President Roosevelt was certainly no feminist, I do not think he would mind my paraphrasing or reshaping that quote:

> "A woman who is good enough to serve or shed her blood for her country is good enough to be given a square deal afterwards. More than that no woman is entitled to, and less than that no woman shall have."

That certainly, I think, is the sentiment of this committee and this subcommittee this morning. We really deeply appreciate your coming and we recognize your common sacrifice to the nation which we all seek to acknowledge through this committee.

Thank you very much.

Ms. VAN DEVANTER. Thank you, Mr. Chairman.

Mrs. MCCLENDON. Thank you very much.

Mr. EDGAR. We will now turn to a panel of witnesses from the veterans organizations: Mr. Paul Egan, deputy director, National Legislative Commission, accompanied by Mr. John F. Sommer, Jr., deputy director of the National Veterans Affairs and Rehabilitation Commission of the American Legion. Also, Mr. John F. Heilman, national legislative director, Disabled American Veterans; and Mr. Peter B. Currier, deputy national service and legislative director of AMVETS.

We welcome all of you here this morning. We appreciate your coming. We will make the full text of your statement a part of the record at this point and, without objection, those statements will be made a part of the record. We ask, in the deference of time—and I know I am always asking you this and I apologize—but to summarize your statements as best you can.

You have heard the issues laid out this morning. You have heard the questions. I think if you have special and unique comments that you would like to make, it would be appropriate at this time.

Let's hear first from Mr. Egan.

STATEMENTS OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AND JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; PETER B. CURRIER, DEPUTY NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMVETS; AND JOHN F. HEILMAN, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. EGAN. Thank you, Mr. Chairman.

In this day and age, it may be impolitic to say so, but I think it is safe to say that, as far as the American Legion is concerned, some of our best veteran friends are women veterans. In that regard, I would like to point out to this committee our close association with Sarah McClendon. She is not only an active Legionnaire, but she was also the recipient of our National Public Relations Award last year.

After having said that, I will turn the microphone over to John Sommer, who is our deputy rehab director, for a summary of our statement.

Mr. EDGAR. Thank you.

STATEMENT OF JOHN F. SOMMER, JR.

Mr. SOMMER. Mr. Chairman, members of the subcommittee, The American Legion certainly appreciates this opportunity to express our views on the status and the future need for medical care provided for women veterans by the Veterans' Administration, and on the other matters that are under the subcommittee's consideration today.

With your permission, Mr. Chairman, may we take this opportunity to express the gratitude of the American Legion to those women who have volunteered, especially during wartime, in the Armed Forces of the United States throughout the history of this Nation and, of course, most recently during the Vietnam conflict. We are proud of the fact that women veterans have been welcomed in our membership since the founding of the Legion in 1919. They have been and are serving as officers, as well as professional employees, of this organization, and we are grateful for the valuable service which they are rendering.

The American Legion is keenly aware of the fact that emphasis needs to be placed on insuring that the medical needs of female veterans may be cared for in every VA medical center and outpatient clinic. It is obvious that women have some special medical needs which must be addressed, and we feel that every VA medical care facility should have the capability of conducting gender-related examinations in the course of providing total physical examinations to determine the status of the female veteran's health.

Likewise, we feel it imperative that inpatient and outpatient gynecological services be readily available for both service-connected and nonservice-connected conditions.

The American Legion supports the enactment of H.R. 1137 which would establish an Advisory Committee on Women Veterans within the VA for the purpose of advising the Administrator on the administration of benefits for, and the special needs of women veterans with respect to compensation, health care, and rehabilitation.

With respect to the GAO report entitled "Actions Needed To Insure That Female Veterans Have Equal Access to VA Benefits," the American Legion has followed up on the activities relative to VA's response to the recommendations that were contained in this report. We are satisfied that in most cases the Department of Medicine and Surgery has initiated improvements in this area.

For instance, DM&S Circular 10-83-14, dated January 28 of this year, provides directives to each facility for furnishing inpatient and outpatient gynecological services for female veterans, and upgrading those facilities needing improvement by June 1, 1983.

The American Legion will be monitoring the implementation of this circular, as well as monitoring the consideration of the special facility needs of female veterans during future construction and renovation projects, and also the revision of privacy standards existing in facilities that are already existing.

With respect to the recommendations by GAO that the VA evaluate female veterans awareness of benefits, and that procedures be established to insure that female veterans will be notified of major changes in benefits that affect them, the American Legion must take exception with the replies that were furnished by the VA. Many women veterans—and this has been pointed out earlier—especially those who served during the Vietnam era, are not as apt to join veterans organizations as are their male counterparts. Further, it has been found that many former servicewomen do not even consider themselves as veterans. So, in many cases, there exists a void in the awareness of eligibility for VA benefits and programs. We feel an effort should be made by the VA to insure that all female veterans are aware of their rightful eligibility to these benefits and programs.

The Legion is encouraged by the recent appointment of Dr. Susan Mather to develop and supervise the changes necessary for the accomplishment of improvements in the provision of specialized medical care for female veterans. She has assured us that the staff of each medical facility is being sensitized with respect to the treatment of women. DM&S Circular 10-83-14 provides the basic directives necessary for the provision of equitable care for female veterans.

The American Legion feels that these are steps toward a more positive awareness of female veterans' needs in all VA health care programs, and we will certainly be monitoring these initiatives to insure that male and female veterans ultimately will have equal access to VA medical care.

Mr. Chairman, that concludes our statement.

[The statement of Mr. Paul S. Egan and Mr. John F. Sommer appears at p. 87.]

Mr. EDGAR. Thank you very much.

We will hear now from Mr. Peter Currier, deputy national service and legislative director of AMVETS.

STATEMENT OF PETER B. CURRIER

Mr. CURRIER. Thank you, Mr. Chairman. AMVETS thanks you for the opportunity to appear before you and offer our views on the current status and projected need for inpatient and outpatient services for women veterans through the Veterans' Administration's Department of Medicine and Surgery.

We also would like to commend you, Mr. Chairman, and Mr. Edwards, and the members of this committee, and the full committee, for this forward step in addressing the needs of the female veterans of America.

It occurs to us, Mr. Chairman, that what we have listened to today, the fine comments from the representatives of the female veterans, as well as our colleagues within the other veterans organizations, that what we have listened to is more than a statement. It is a consensus of opinion over a problem that has long faced societies, not only American but others as well.

It also occurs to us that we are not here to address and indict any particular individual or individuals, or any agency, but rather to assail a mentality which has long pervaded all aspects of our society, and others before us. It is time now for us to recognize the equitable care and recognition of our female population. We feel that the Veterans' Administration for a long time—not necessarily due to their own fault or intentions, but because of the mentality which has pervaded societies—has long failed to recognize that, indeed, females, women, are people, too.

We are pleased with the introduction of this resolution, because we feel that a certain amount of oversight will be provided of the Veterans' Administration, and we are also pleased that the Veterans' Administration has reacted, under the guidance of Administrator Walters, to the GAO report, and is actively attempting to address the needs of women veterans by assessing their own availability for gynecological care, their own provisions for privacy in the hospitals, and we believe it is their intent at this time, to rectify any deficiencies in this area.

We are also pleased that Administrator Walters and his staff have undertaken an effort to publicize benefits which are available to female veterans. We believe this is the crux of the problem. We would be hopeful that the Veterans' Administration will engage in a far-reaching public relations effort which will let the female veterans of America know of the many benefits which are available by law. We hope this is the first step in a process which we would hope will not take too long, to turning around the attitudes of many individuals toward the care of female veterans.

I might add, Mr. Chairman, in closing, that we canvassed our national service officers and our State service officers, and we are proud of the fact that several of our national and State service officers are women, who are among the most professional, dedicated, and compassionate individuals I have had the pleasure to be associated with. By and large, they reflected what we stated, that at the present time the need for services, as indicated, is being taken care of. However, there is a need to reach out to these female veterans and bring them into the Veterans' Administration for care.

Thank you for the opportunity to appear.

[The statement of Peter B. Currier appears at p. 90.]

Mr. EDGAR. Thank you very much for your statement.

Our next witness will be Mr. John Heilman, national legislative director, Disabled American Veterans.

STATEMENT OF JOHN F. HEILMAN

Mr. HEILMAN. Good morning, Mr. Chairman, members of the subcommittee. For the record, I would like to state that since its inception in 1922, and continuing to the present day, the DAV has welcomed to its membership all honorably discharged veterans who have incurred a service-related disability as a result of wartime service, both male and female alike.

Currently the State DAV organizations are headed by female veterans in Utah, Hawaii, and Florida, having been elected to that position by their DAV membership in that State. Three of our national service officers, those full-time paid employees who represent VA claimants throughout the country, are service-connected disabled women veterans, two from the Vietnam era.

With regard to H.R. 1137, we do strongly support its favorable consideration and enactment into law. We applaud Administrator Walters and his staff for the steps they are taking with regard to setting up an advisory committee, but we do believe it is wise to have the Congress statutorily require such a committee.

I would like to make three comments relative to the bill that we hope you will consider during your deliberations on the measure.

No. 1, we strongly believe the committee should be headed by a woman. Now, one might feel that will obviously follow. Well, it may or may not. We are not asking that it be a statutory requirement but we believe in the report language that accompanies the bill the committee definitely states its intent that this should be so.

Second, and again referring to the membership of the committee, the bill provides one category of membership to be composed of individuals who have expertise and are recognized authorities in fields that are pertinent to the health care needs of female veterans. Again, we would ask for a statement of intent on the part of the committee in the report on the bill, that where otherwise qualified, these individuals be women. We think it is especially important in the area of experts in gynecology.

Third, the bill makes no statutory requirement on the number of times the committee shall meet. We think it might be wise to do so, and we would ask you to consider putting in a minimum number of times per year that the committee shall be required to meet by law.

Regarding the GAO report, I won't enumerate its views and findings. Obviously, women veterans do not have equal access into our VA health care system, and once in there, they do not receive care equal to their male counterparts. The reasons for this bias and discrimination are obvious and have been covered this morning. I don't think it is really necessary to delve into why this has occurred, but the simple fact is it does exist and it must be addressed.

I would ask you to note in my prepared statement that I have attached the views of one of our female service-connected disabled veterans of the Vietnam Era. When I was apprised of these hearings, I posed questions to her concerning the health care needs of female veterans. I felt she was a particularly qualified observer in this respect. She is female; she is a service-connected disabled; and she is professionally involved in counseling both male and female veterans on their entitlement to benefits.

I believe you will note that her views parallel those contained in the GAO report, particularly in the area of the communal nature of sleeping and bathing arrangements in VA hospitals; the deficiencies in the area of physical exams, specifically pelvic, breast exams, and Pap smears; deficiencies that exist in the area of fee basis care, the fact that women veterans do not have access to this type of care as do male veterans.

Finally, she commented on, in some cases, the attitudinal problems on the part of VA employees, and also some male veteran patients.

I would just make one final comment on this issue. The health care needs of our female veterans, both service-connected and non-service-connected, have to be met. In the short run, the VA is most likely going to have to utilize fee basis contract care and care delivered through arrangements with military medical facilities, and also medical schools that are affiliated with the system. But the long-range goal of the VA should be to provide in-house care, comprehensive in-house care for the inpatient and outpatient needs of female veterans. To deal with this need on any other basis would be to continue the discrimination that we recognize exists in the system.

[The statement of John F. Heilman appears at p. 91.]

Mr. EDGAR. Thank you very much.

Your three suggestions to our bill are very well taken, the first two as report language to make sure it is the preference that the head of that committee be a woman, and that women have an opportunity to be female doctors in those fee basis situations and all the consulting that goes on. And your third point is well taken, about a fixed time and number of meetings within the legislation, we will take that under consideration.

As I understand, all three organizations support the establishment of this advisory committee in law; is that correct?

Mr. **HEILMAN**. Yes, sir.

Mr. **EDGAR**. And all three of you would hope that we would upgrade the level and quality of health care delivered to women within the VA?

Mr. **CURRIER**. Definitely.

Mr. **HEILMAN**. That's correct, sir.

Mr. **EDGAR**. I yield to my colleague from Connecticut, Mrs. Johnson.

Mrs. **JOHNSON**. Thank you, Mr. Chairman.

Thank you very much for your testimony this morning. I think the chairman's summary is accurate and, in view of the hour and those yet to testify, I would just thank you for being with us this morning and for your strong support of quality health care for women and of the advisory panel for women.

Mr. **EDGAR**. Thank you very much.

I yield to my colleague from California, Mr. Edwards.

Mr. **EDWARDS**. Thank you, Mr. Chairman.

I don't think that AMVETS has endorsed this bill, according to your testimony, Mr. Currier.

Mr. **CURRIER**. We have, by our testimony, Mr. Edwards, endorsed the bill as a need. We do believe——

Mr. **EDWARDS**. Where do you say that in your testimony?

Mr. **CURRIER**. We have not clearly stated it. It is implied, and I am stating for the record that we do endorse this bill.

Mr. **EDWARDS**. Very good.

Mr. Currier, your statement said that you canvassed national service officers with regard to any possible deficiencies in medical care for female veterans. How many did you talk to? How many did you survey, the female members of AMVETS?

Mr. **CURRIER**. Well, we canvassed our national service officers. We have on staff right now 45 national service officers, of which three are females. We have several State service officers.

In our canvassing procedure, we sent letters to each national service officer, including these females, and made them available to our State service officers.

Mr. **EDWARDS**. And these women all advised you that the medical needs of the female veterans are being adequately met by the VA?

Mr. **CURRIER**. Their comments couched around the fact, first, that by and large, with the exception of the gender-related disorders, that health care for female veterans in much the same for women as for men—with the exception of the gender-related disorders.

Now, in that respect, they said that the gender-related disorders are being met on a contract basis satisfactorily, according to the indicated needs. Now, they also said that in many instances, in most instances, as a matter of fact, of the NSO's that reported, stated that there was a low usage of the VA facilities. And as we indicated in our prepared testimony, we feel this is a lack of public relations, that many women do not know of the benefits that are available to them and the quality of care which they are eligible to receive through the Veterans' Administration.

By and large they said yes, the health care needs, as indicated, are being met by the Veterans' Administration. In fact, I have had the opportunity personally to talk to hospitalized female veterans and the consensus was that the care they were receiving was excellent from a medical standpoint. There was some question as to privacy, which we have stated is a problem that is recognized by the Veterans Administration. They are attempting to deal with it through a self-examination process.

Mr. **Edwards**. How many of these members of AMVETS who are female would you say that you talked to or inquired of?

Mr. **Currier**. Well, through our procedure, through our national service officers and State service officers, I would say there was 10 seasoned service officers—by that I mean experienced service officers, long-term in nature.

Mr. **Edwards**. After hearing the testimony today, are you going to ask them again?

Mr. **Currier**. Well, I am going to go back and ask them to specifically address certain things, which I would be happy to submit to the committee for the record.

Mr. **Edgar**. Let me throw out a question—and I appreciate my colleague, Mr. Edwards, clarifying the position of AMVETS. I think it is important for us to be as clear as we can on this issue.

One question that I think all of the service organizations ought to consider is, in the interim between the establishment, either by law or by Executive order, of an advisory committee on women's issues, whether or not we shouldn't develop legislation, enacted quickly, to provide in the short term fee basis outpatient care for service-connected and nonservice-connected women veterans, until the Veterans' Administration, in whole or in part, can adequately provide for those services.

Mr. **Currier**. Without question.

Mr. **Egan**. Mr. Chairman, much the way contract care is available to Puerto Rico, I think it may, indeed, be appropriate to do that. We will have to reserve judgment until we have had a chance to look at the legislation specifically.

Mr. **Edgar**. Thank you very much.

Mr. Bilirakis, do you have any questions for this panel?

Mr. **Bilirakis**. Sir, not having heard their testimony, I don't think so. My questions and my thoughts are more in the general vein or general sense which I think would be applicable to any of the witness.

Mr. **Edgar**. OK. Thank you very much and thank you for your testimony this morning.

Our next witness will be Mr. Robert Peterson, Senior Associate Director of the Human Resources Division, General Accounting Office.

I am going to ask my colleague, Don Edwards, to chair the hearing for about 5 minutes.

Mr. **Edwards** [presiding]. Without objection, your full statement will be made a part of the record. Would you introduce your colleague and please proceed.

STATEMENT OF ROBERT A. PETERSON, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY KAY BAKER, SAN FRANCISCO REGIONAL OFFICE

Mr. PETERSON. Thank you very much, Mr. Chairman.

On my right is Ms. Kay Baker from our San Francisco Regional Office, who was in charge of the study that we will be discussing today.

Mr. Chairman and members of the subcommittee, we are pleased to be here today to discuss our September 1982 report on female veterans' access to VA health benefits.

VA health care programs have typically been oriented to male health care needs because most veterans are male. The need to plan for and provide medical care that meets the special needs of female veterans is becoming more important as their numbers increase.

Because of the lack of privacy at older VA facilities, women, including those with service-connected disabilities, could not obtain some specialized medical care. Although staff and patients were sometimes inconvenienced, medical-surgical facilities were generally able to handle the current number of female patients. However, psychiatric facilities and domiciliaries were not.

Women could not participate in some treatment programs at two of the six psychiatric facilities we contacted. For example, women were not admitted to two specialized treatment programs at the Brentwood, Calif. VA medical center because they could not be assured adequate privacy. According to Brentwood's chief of psychiatry, staffing changes were made in May 1982 to permit women to be admitted to one of the two programs.

Neither service-connected or nonservice-connected female veterans were admitted to 10 of VA's 16 domiciliaries because of a lack of privacy in sleeping and toilet facilities. VA has recognized the problem and has required domiciliaries that do not accept females to include in their 5-year renovation plans modifications designed to accommodate women.

Women with nonservice-connected disabilities could not always get gynecological care, and women with normal pregnancies could not obtain obstetrical care.

Pelvic examinations and Pap smears are important techniques for detecting cancer in women. However, only one medical center we visited, Syracuse, had reviewed patients' medical charts to monitor the completeness of female patients' physical examinations. This facility found that, in May and June, 1981, pelvic examinations had been done for only 20 percent of the female patients; breast examinations for only 40 percent; and Pap smears for none. At two other facilities, Houston and San Francisco, medical staff acknowledged that pelvic examinations were not routinely done.

VA medical centers and independent outpatient clinics use various methods to provide gynecological care. While most facilities satisfactorily served female patients, 7 of 23 VA facilities contacted depended primarily on the fee-basis program to provide outpatient gynecological care. Because of restrictions on the availability of fee-basis care, nonservice-connected women were not eligible for outpatient gynecological treatment at these facilities.

We have long encouraged sharing of Federal medical resources between VA and the Department of Defense as a way to better use Federal facilities and thus reduce health care costs. One method the VA facilities could use to provide care to nonservice-connected female veterans is sharing agreements with military hospitals. Such sharing is now authorized under the VA and DOD Health Resources Sharing and Emergency Operations Act. Because DOD hospitals have traditionally provided care to spouses and dependents, they are more attuned to the needs of female patients. Accordingly, we believe VA could expand its ability to meet female veterans' needs through sharing agreements with DOD hospitals.

VA has not adequately considered the increasing female veteran population in long-range planning for construction and renovation projects or in designing facility renovations. In October 1981, VA established a medical district initiated program planning process to develop 5-year plans. The initial phase, completed in March 1982, required medical centers to identify factors limiting service delivery. Although female veterans do not have access to some VA facilities and treatment programs, none of the 28 medical district submissions identified any factors limiting females access to VA medical centers or treatment programs.

Further, data submitted by the medical districts on the current and projected veteran population to be served reflected total veterans without a breakdown by sex. Without projections on the female population likely to need VA health care, VA cannot determine if its facilities can accommodate future demand.

Facilities that are renovated to provide more patient privacy still may not be able to accommodate female veterans because VA's privacy standards do not insure that female patients are provided privacy in shower facilities. For example, part of the domiciliary at the Hampton, Va. medical center was renovated in 1977–78 to improve privacy in sleeping quarters, but no change was made in the communal bathrooms. Because there are no private bathrooms for female veterans, the domiciliary did not accept females even after the renovations.

The readjustment counseling program for veterans of the Vietnam era, a program established in 1979 to provide counseling to veterans having difficulty readjusting to civilian life, was specifically addressing female veterans' needs. The veteran counseling centers were training staff on female veterans' readjustment problems, compiling statistics on female veterans seeking help, and performing outreach to female veterans.

We made several recommendations to correct the problems just discussed and have been encouraged by the actions the VA has initiated.

In a January 1983 circular, VA directed each medical center and outpatient clinic to develop and submit to central office by June 30, 1983, a written plan for the care of female veterans. The plans are to address, at a minimum: the definition of a complete physical examination for a female as including breast examination and pelvic examination; provision of inpatient gynecologic services for hospitalized female veterans as well as those in VA nursing homes and domiciliaries; provision of outpatient gynecologic services to both service-connected and nonservice-connected veterans; and referral procedures so that female veterans can receive necessary services currently unavailable at the medical center because of privacy considerations.

The circular also directs the facilities to review their current method of providing outpatient gynecological services and upgrade those needing improvement by June 1, 1983. The circular specifically states that reliance on fee-basis care alone is not adequate.

Finally, the circular directs each medical center to examine admitting areas, outpatient clinics, and bed services to identify physical barriers such as lack of privacy or bath facilities that limit access of females to any program. Plans for correction of barriers are to be incorporated in the 5-year construction plan for fiscal years 1985 through 1989, unless the necessary renovations or new construction are underway prior to that time.

We believe the actions taken by the VA, if effectively implemented, should significantly improve female veterans access to VA health care.

Mr. Chairman, this concludes my statement. We will be happy to respond to any questions you or members of the subcommittee may have.

[The statement of Robert A. Peterson appears at p. 97.]

Mr. **Edwards**. Thank you very much, Mr. Peterson. We all commend you for your very excellent report.

Mrs. Johnson?

Mrs. **Johnson**. Thank you, Mr. Peterson. I share the chairman's sentiments in terms of the quality of your report.

Are you satisified that if there is effective followup on the circulars that have been issued to this point, that there will be no disparity between the treatment of non-service-connected medical needs of female and male veterans?

Mr. **Peterson**. That ought to be the ultimate result. Of course, it will depend on the quality of the work done at the medical centers to identify the barriers and the problems that women have been facing in that particular medical center and the followup action that is taken, yes.

Mrs. **Johnson**. Thank you. I am sure we will be a part of following that implementation as well.

Mr. **Edwards**. Mr. Bilirakis.

Mr. **Bilirakis**. Well, sir, I have the same question and same thought in my mind as I had earlier, and possibly my question regarding certification of the plans and specifications for construction has been answered during my absence. But I am pleased and certainly not surprised, because having met the new VA Administrator, I expected this type of conduct and action on his part. I think he is a good man who is going to do the job that our veterans need and definitely deserve.

Of course, I have the concern about politics. I have the concern that if you change administrations and what not—not that I anticipate that happening—but, you know, you may change administrators. So I don't like to see anything just put in the lap of the Administrator of the VA. It should be out of politics, I should think.

Is there not some sort of a required legal certification—I mean, I can't build a home in my little hometown without getting some sort of certification as to safety standards and requirements and all of the things that are necessary. Does that not exist as far as VA facilities is concerned?

Mr. **Peterson**. Well, it exists in very great extent due to the fact that the VA contracts with architect-engineers and at each phase of the project's development those plans are reviewed and they have to meet VA's standards. One of the standards that we looked at that is not adequate is the privacy standard that can result in situations such as I have described. Even after a facility is renovated, it still did not accommodate women. So there are standards, but they are not always perfect.

Mr. **Bilirakis**. And you feel that when the responses come in from this circular, and those responses are cranked into those standards, that that should do the job?

Mr. **Peterson**. I would hope so.

I think there is one big difference between the circular that went out in January 1983 as opposed to the circular that went out in January 1981, prior to our study. That one, if you read it on its face, lays out pretty specifically what an adequate examination for a female veteran is and does, in fact, require breast examinations and pelvic examinations. The difference is that information will be flowing back to VA's Central Office under the 1983 circular, where the 1981 circular required medical centers to monitor the physical examinations given to female veterans. Only one of the facilities that we visited was doing that, and that was Syracuse. The results were as I stated. Very few females had received pelvic examinations or Pap smears or breast examinations. Two others acknowledged that they did not routinely do certain things that they were required to do.

Getting the Central Office more actively involved by getting the data back up and evaluating it is a big difference in the two circulars that were issued.

Mr. **Bilirakis**. Thank you, sir.

Miss Kaptur alluded to the field trips that we have coming up to the various hospitals. Hopefully we all will keep today's session in mind. I know Mrs. Johnson certainly will and hopefully she will keep the rest of us reminded so that we may make the proper inquiries at all those hospitals that we visit.

Thank you.

Mr. **Edwards**. Mr. Peterson, when you did your report and your study, did you do also an attitudinal survey of Veterans' Administration employees' perception of women veterans?

Mr. **Peterson**. No, we didn't. I will let Kay Baker speak to this. But I think her sense from visiting many facilities is that there is an awareness problem out there as opposed to a resistance problem. Kay, I would ask you to say something on that.

Ms. **Baker**. I would definitely agree with that. We talked with not only the physicians and administrative staff but quite a number of the nurses, too. As I think was mentioned earlier, it was the nurses who more often were in tune with some of these particular problems because they were the ones that had to make the room arrangements and transfer the patients or stand guard.

We found in a few instances that people weren't aware of the legislation that does exist for fee basis in-hospital care for service-connected and nonservice-connected, even though it was in existence at the time, that there was just a lack of awareness.

I think we also found in a number of instances it would not have required major work or major efforts to correct some of the facilities' problems that existed. It was just no one had thought of it, to install a certain new type of lock or, during the renovation, if they were going to subdivide a room and add a sink and a toilet, to add a shower, also.

So we felt if someone had just thought about it, if there had been more focus on the issue, with some minor effort some of those problems could have been addressed.

Mr. **Edwards**. Thank you.

I believe there is a vote on the House floor. The subcommittee will recess for 5 or 10 minutes.

[Whereupon, the subcommittee was in recess.]

Mr. **Edgar** [presiding]. The committee will come to order.

I would like to apologize to our GAO witnesses that I had to step out when you were giving your statement, and then we had two votes, one on top of the other. I appreciate your coming this morning and I appreciate Don Edwards chairing the meeting. Let me just ask a couple of questions.

What do you consider to be the most important recommendation that came from your report, and what do you consider to be the most serious discrepancy?

Mr. **Peterson**. I would put two things in the most important category; that is the awareness issue, increasing the awareness so that that can be part of the long-range planning. As I indicated in the prepared statement, the VA's long-range planning really has not adequately considered the increasing number of female veterans, including the lack of data on the number of females likely to seek treatment. I think that is where the focus ought to be right now.

The biggest deficiency in the current services offered clearly was in the area of outpatient treatment to non-service-connected female veterans.

Mr. **Edgar**. We were shocked to learn that the VA and the Department of Defense did not even know how many women served in Vietnam. In your view, is this a difficult kind of information to discover?

Mr. **Peterson**. The best information we have, as was presented by an earlier witness, is that the Department of Defense has made a concerted effort not to have sex or race information on its records, so it is extremely difficult for one to extract information on how many women served in Vietnam, yes.

Mr. **Edgar**. So you don't think it would be difficult to——

Mr. **Peterson**. Yes, it would be difficult.

Mr. **Edgar**. You think it would be difficult?

Mr. **Peterson**. Yes.

Kay, do you have additional information on that?

Ms. **Baker**. I would agree, because not only on the records for Vietnam but on the DD-214, their discharge form, we looked at a variety of formats. They have changed the format over the years. On some they have an indication of male or female and on some they do not. Some of those were during the Vietnam era when they did not have that indicated on their discharge papers, also.

Mr. EDGAR. What do they have on the discharge papers today?

Ms. BAKER. I don't know that I could tell you what the latest is. The last one we looked at, it was not on there. I don't know what it is today.

Mr. EDGAR. If, in fact, an advisory committee were established in the VA, one potential recommendation would be that the bookkeeping and reporting system for future veterans be clarified. I am sure the GAO could assist in determining what kinds of procedures might make the best sense.

Let me ask you just one other question. You state on page 3 of your testimony that "Women with normal pregnancies could not obtain obstetrical care" at a VA facility. Is it not the case that the VA, under terms of a recent court decision, is not authorized to provide routine obstetrical care but is only allowed to provide care when complications arise with that pregnancy?

Mr. PETERSON. That is correct.

Mr. EDGAR. So that is a matter of a court decision.

Mr. PETERSON. Yes. That has been tested in the courts once.

Mr. EDGAR. In the fiscal 1984 budget, the VA has asked for funds to do a survey of female veterans and have included a question on service in the Vietnam theater. Do you think that is realistic?

Mr. PETERSON. I am not familiar with that particular request, Mr. Chairman, but in our report we felt that there should be a special outreach effort to female veterans, to make them aware of the benefits and so forth. So if——

Mr. EDGAR. We will ask that [illegible] question of the VA.

Thank you very much. We [illegible] have some questions that we will submit for the record. Your [illegible] this morning is commendable and we appreciate your time and [illegible] on this important issue.

Mr. PETERSON. Thank you, Mr. Chairman.

Mr. EDGAR. Our final witness [illegible] morning will be Dr. Donald L. Custis, Chief Medical Director [illegible] Veterans Administration. Dr. Custis, we invite you to come [illegible]. We welcome you this morning, and those of the VA staff who are with you.

Before you begin your testimony, let me just try to add just a word of balance to our hearing this morning.

As you are aware, there are many issues that confront the VA in terms of its construction facilities, its health care delivery system, the age of the system, the quality of care in each of its facilities, its research capabilities, and many other important areas of veterans consideration. We have zeroed in on a microcosm of that veterans health care system in looking at the role which the VA has traditionally, and will in the future, play in responding to the health care needs of women and women veterans.

I think in fairness to the VA it should be stated for the record that there are a number of very qualified physicians and nurses and staff who provide quality care to thousands and thousands of veterans every day. We are in no way trying to attempt this morning to have the record show that the VA has done a terrible job in all of the aspects of health care delivery.

As the new chairman of this subcommittee, I thought it important that we look at some of the specialized problems, and sometimes when we focus on the problems we have a difficult time looking at the positive side. I was struck by the comments in the research paper that was done by our master's student who appeared on the first panel when she said that reports came back on how the women veterans, particularly the Vietnam era veterans, wanted to say some positive things about their experience. I think the male veterans also have discovered that they want to say some positive things about their service and their readjustment back into our society.

Before you begin your statement, I just wanted to say that there are many positive areas within the VA health care facilities. This is an area of concern and we are trying to get at the facts as they are presently and what changes we can make. We appreciate your patience in being the last witness and the fact that you came early to hear and to listen to the concerns as expressed by both the panel of women as well as the panel that dealt with the service organizations. It is very commendable.

We are now at the point of hearing the statement from the VA. Your full statement will be made a part of the record and we ask that you summarize, where possible, so that we can move to some questions.

STATEMENT OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION: ACCOMPANIED BY NORA KINZER, PH. D., SPECIAL ASSISTANT TO THE ADMINISTRATOR; SUSAN MATHER, M.D., PROFESSIONAL SERVICES DEPARTMENT; DOROTHY STARBUCK, CHIEF, DEPARTMENT OF VETERANS BENEFITS; AND JOHN MURPHY, GENERAL COUNSEL

Dr. CUSTIS. Thank you, Mr. Chairman. We, too, are pleased to be here. We appreciate and share the concerns of the committee on this very important subject.

At the outset, Mr. Chairman, let me assure you that the Veterans' Administration is, indeed, committed to providing equitable care to all veterans, male and female, and we have made adjustments over the years to accommodate the special needs of the female veterans.

May I stop for just a minute and introduce my colleagues. I should have done it at the onset. Dr. Nora Kinzer, special assistant to the Administrator, and Dr. Susan Mather, of the Professional Services Department, who also is the DM&S representative on the Administrator's new Advisory Committee. Miss Dorothy Starbuck is well known to you, the head of the Department of Veterans Benefits, and our General Counsel, Mr. John Murphy.

Mr. Chairman, traditionally, historically, we all know that the veteran population has been comprised almost exclusively of males, and perhaps understandably, for that reason, the VA health care system has, indeed, been a "man's world." But it is becoming less so. Now, especially under the proactive leadership of Administrator Walters, we intend to take every initiative to complete that change of profile.

The VA has, of course, long been aware of the increasing number of women veterans and has taken this into account in its planning process.

May I interrupt here just 1 minute to say extemporaneously that there have been so many statements made this morning that are based on lack of knowledge or lack of full facts. We would be delighted, if you so wish, to review the record and furnish for the record such facts that have been perhaps misunderstood this morning.

Mr. **EDGAR**. Without objection, the record will stay open for a few days for your response, as well as for the response of others to your statement. We want the record to be clarified as much as possible.

Dr. **CUSTIS**. We would appreciate that.

A couple of examples. I can assure you that military records contain the sex of the member. Military medical records all contain an identification of sex. Our guidance for MEDIPP, has specific guidance for planning for the care of female veterans. We have in our construction program been working toward privacy for the last 10 years. In fact, we have lost 7,000 beds in the construction effort to place privacy in our obsolete hospitals. We know exactly where privacy is still lacking. Over the period of the coming 5 years we will lose about 5,000 more beds in that construction effort to correct the lack of privacy as well as fire and safety deficiencies.

VA policy has long provided for obtaining services on a fee basis, or through other contractual arrangements, if VA medical centers determine that available staff or consultants cannot render necessary services.

I think, Mr. Chairman, there is a need to get into the record exactly what the scope of eligibility for fee basis care is. For example, it apparently isn't known today, as matters stand right now, that the female veterans enjoy greater disability for fee basis care than do male veterans.

[Subsequently, the Veterans' Administration furnished the following information:]

Female veterans have the same basic eligibility for medical care as do male veterans for both inpatient and outpatient or ambulatory care services. In addition, certain eligibility provisions are unique to female veterans.

Female veterans needing hospitalization for either service-connected or nonservice-connected conditions may be authorized inpatient care at a non-VA facility if VA and other Government facilities are incapable of furnishing the hospital care they need.

They have no special eligibility for fee basis care, but like male veterans they may be placed on fee basis for post-hospital care of nonservice-connected conditions for which they received VA hospital care. (M-1, Part I, Chapter 17, paragraph 17.24) Veterans Administration Regulation 6048(E) excludes entitlement to care for pregnancy or parturition unless complicated by a pathological condition.

Dr. **CUSTIS**. To reemphasize this policy, a January 28, 1981 information letter was issued to remind all medical centers and outpatient clinics that they should take steps necessary to meet the special needs of female veterans. The letter also suggested methods of insuring that female patients receive quality services.

For example, in 1981, for contract hospitalization alone, for female nonservice-connected veterans, $1.3 million was expended.

In September of 1982, a survey of VA facilities was conducted, in conjunction with the GAO effort, but on the part of the VA to collect data for planning purposes regarding provision of medical services to female veterans. This survey showed that the majority of our facilities are currently providing care for females and are using a variety of mechanisms to provide gynecologic care. Specifically, that survey shows—and Dr. Mather can correct me if I don't have the exact numbers—that 80 percent of our hospitals have privacy arrangements for females, and 85 percent of our nursing homes——

Dr. MATHER. It's higher. It is 88 percent on medical and surgical wards, and 83 percent on psychiatric facilities. It is 86 percent of the nursing homes that provide adequate privacy.

Dr. CUSTIS. We will provide for the record the full information from this survey, Mr. Chairman.

[Subsequently, the Veterans' Adminsitration furnished for the record the report of the Survey of Care of Female Veterans:]

RESULTS OF CIRCULAR (QUESTIONNAIRE) 10-82-113 RCS 11-238-S CARE OF FEMALE VETERANS

1. The data represents 171 responses from 160 VA medical centers, 7 OPCs, 1 independent domiciliary and 3 regional offices.

2. 26 VA medical centers have written plans for the care of gender-related conditions of female veterans. 5 more have such plans in progress. 4 have plans limited to specific conditions such as pregnancy or rape.

3. There is no uniformity to the pattern of services offered at different facilities. (See table below) 90 listed at least two mechanisms for providing services for gender-related conditions. The use of consultants or attending physicians is the most popular mechanism with 113 stations reporting that they utilized this method. 45 reported this as the only mechanism they used for care of female gender-related conditions.

91 stations reported having some in-house-capability. 6 used 4117 (scarce medical services/specialist) contracts and 21 had sharing agreements. Two facilities reported that they had sharing agreements in process with military installations. 24 facilities reported that they handled female gender-related conditions by referring them to another VA medical center. 45 reported the use of fee basis care.

Nine reported using only fee basis for the care of female gender-related conditions while 13 had only fee-basis care and some in-house capability.

Mechanisms of providing gynecologic services are summarized in the following table:

Mechanisms for providing gynecologic services in VA facilities

Service provision:	*Number stations using*
Consultants or Attendings	113
Only consultants/attendings	45
In-house Capability	91
4117 Contracts (scarce medical services)	6
Sharing agreements	21
Referral to Another VAMC	24
Fee Basis Care	45
Only fee basis	9
Only fee basis plus in-house	13
Two or more ways of providing service	90

4. The following chart summarizes those facilities reporting inability or limited ability to care for females on various bed services and in special programs because of privacy considerations as well as those with reported renovations planned or in progress to correct current deficiencies:

NUMBERS OF VA FACILITIES WITH LIMITED SERVICES TO FEMALE VETERANS BECAUSE OF PRIVACY CONSIDERATIONS ON BED SERVICES

Bed services (numbers)	Privacy considerations		Renovations in progress
	Inadequate	Limited	
Medicine (160)	7	9	2
Surgery (135)	6	8	2
Psychiatry (128)	11	8	4
Special programs (126) (for example rehabilitation, alcohol treatment, et cetera)	15	5	5
ADTP/DDTP	4		
Nursing homes (99)	9	4	1
Domiciliaries (16)	9	1	1

5. 130 stations reported the waiting time for a GYN appointment to be less than 2 weeks at their facilities while 26 reported 2-4 weeks and 7 reported more than 4 weeks. 8 did not specify the waiting time.

6. 36 Stations reported no gynecologic consultations done at their facilities in FY 81, the remainder reported a total of approximately 6600 consultations, approximately 600 C&P exams included a GYN evaluation. 724 gynecologic surgical procedures were done at VA medical centers in FY 81 or authorized at other facilities.

7. 12 VA medical centers audit pelvic examinations. PAP smears and breast examinations as a part of their SIR program. 1 audits pelvic exams only. All but 4 Facilities reported having proper equipment for such exams.

Dr. CUSTIS. As you know, the General Accounting Office published a report which we have heard about this morning. The report made a number of recommendations, many of which we were able to agree with in whole or in part. We were, at the time of their survey, taking actions that addressed the same concerns raised by the GAO, and considerable progress has since been made in implementing many of those recommendations. The opening statement that is presented here for the record identifies what those specific steps are.

Mr. EDGAR. Dr. Custis, if I could interrupt you, I think the compliments came from most witnesses, that since the arrival of the new Administrator there have been a lot of documented things that have happened in this area. We commend that and hope it will continue.

Dr. CUSTIS. Mr. Chairman, for the sake of brevity, and to get on to a dialog, I am going to skip any other remarks and come down to the point where you requested we testify on H.R. 1137, a bill "To amend Title 38, United States Code, to establish the Veterans' Administration Advisory Committee on Women Veterans."

H.R. 1137 seeks to codify a decision which, in our experience, is more appropriately left to administrative discretion and which, in fact, has already been made within the VA. Additionally, provisions of the bill are, in our view, unnecessarily restrictive and may hinder our efforts to accomplish the bill's purpose.

We certainly agree in principle with what appears to be the major purpose underlying H.R. 1137, that is, the desirability of providing the Administrator a broad spectrum of views to assist the agency in planning to meet the needs of women veterans. However, we cannot agree with the premise that legislation is necessary or even desirable to accomplish this.

The Administrator has broad authority to obtain advice and assistance in planning and administering the agency's programs. In fact, shortly after his confirmation, the Administrator directed VA department heads to take steps to facilitate the administrative establishment of an advisory committee on women veterans. A measure such as H.R. 1137, which mandates that establishment, mission, general composition, duration, reporting requirements, and mode of operation of an advisory committee, deprives this agency of the discretion and flexibility so important to sound program administration. Instead of a flexible tool to respond to agency needs, the advisory committee to be established under this proposal represents, in our opinion, a mechanism which, in its rigidity, could actually prove a greater burden than a benefit.

In summary, Mr. Chairman, we do agree in principle with the purpose, namely, the provision of advisory input, but we sincerely prefer that it be accomplished through an administrative route.

All of us would be happy to receive any questions.

[The statement of Dr. Donald Custis appears at p. 114.]

Mr. EDGAR. Thank you, Dr. Custis.

Dr. Custis, how long have you been with the Veterans' Administration?

Dr. CUSTIS. Since 1976.

Mr. EDGAR. And since that time there have been three Administrators, or four?

Dr. CUSTIS. Four.

Mr. EDGAR. Have they all had the same consistent vigor that our present Administrator has had on the issues relating to women's issues?

Dr. CUSTIS. They all had their attributes, Mr. Chairman. I think none matched Mr. Walters on this particular issue.

Mr. EDGAR. I guess that is really the crux of why I am such a strong supporter of the legislation, that administrations come and go and Administrators come and go, chief medical directors come and go, and people in policy areas, in construction and others, come and go. Yet the issues as outlined in the overall general view is that there will be more, not less, female veterans in the future; that if it is such a good idea and aggressively pursued by the present Administrator, then it probably should be a good idea 2 years or 6 years from now, when there may be a new administration or a new set of Administrators to run the agency.

You spoke in your statement about the rigidity of the advisory committee. We are really open, and one of the reasons we asked you to comment on that legislation is for suggestions on how that advisory committee could be flexible and nonrigid in its focus and operation.

We heard from the Disabled American Veterans some very good recommendations on how we might improve both the letter of the legislation and the intent of the report language which we think will follow. I am not asking you to change your statement, which I assume has been approved through the chain of command in the Administration, but I do wonder out loud with you whether or not, if this is such a good idea, that the Administrator is so excited about, why it would not be a good idea 5 years from now, 10 years from now, and what assurances do we have that an advisory board set up solely by the executive branch, without any reporting requirements to the Congress of the United States, would have any effective long-term advising capacity within the Administration and within Congress, other than subject to the whims of the Administrator?

Mr. **Murphy**. Mr. Chairman, if I can add a few comments to that—

Mr. **Edgar**. Could you state your name just so the record is clear?

Mr. **Murphy**. John Murphy, General Counsel of the Veterans' Administration.

I think one of the primary and obvious indications that an advisory committee is not necessarily advisable to be embodied by statute or on a permanent basis is the existence of this committee and similar oversight committees in the other house, the Senate——

Mr. **Edgar**. If the gentleman would yield, self-criticism is always good for the soul. I have been on this committee for 8 years and this committee has not always been as active and as aggressive in its oversight capabilities as they relate to women veterans. I think today was the first time I have heard this committee actually deal with the issue in an upfront way. It is clearly the first time we have heard from so many witnesses that have concern and compassion for the quality of women's issues. I can tell you that not every member of this committee, without disparaging anyone, has been excited about dealing with the issue of women veterans.

So, to the point you make about our oversight capabilities, I think it is a little bit——

Mr. **Murphy**. I think we are in the same boat, the agency and the committee, in that now that there has been an awareness and through a variety of events there is an awareness. I don't think, in my opinion, that you can presume the awareness will somehow die out, either in the agency or in Congress.

Dr. **Custis**. Mr. Chairman, I can't resist telling you that when I was smiling a little while ago when you were talking, the reason for my smile was that my colleagues passed me a note saying this Congress and this committee has not previously had such a hearing.

Mr. **Edgar**. Absolutely. I think we are both well aware of that.

Mr. **Murphy**. Mr. Chairman, if I could add one other comment on the bill, just because I would like to get it out for thought and consideration, you made the gracious offer of ongoing discussions as to how to deal with the committee, which certainly we appreciate. I think in one respect that indicates why this Administrator and this administration would appreciate some of the added flexibility that comes from an administrative establishment.

Mr. **Edgar**. I would just state for the record that this is the first time I have been chairman of the Hospitals and Health Care Subcommittee and able to schedule hearings. That may be a reason for the change at this level. So with a new Administrator at the VA and a new chairman of this committee, maybe we will raise the consciousness on this issue.

Let me ask another specific question. During the last Congress, Public Law 97-37 enacted a permanent advisery committee within the Veterans' Administration to address the needs of veterans who are former prisoners of war. Perhaps Miss Starbuck or Dr. Custis could answer the question, which is what has been the VA's experience with that committee? Do you find it a commission that is too rigid for the flexibility of the Administrator, because that was a commission that was enacted by the Congress of the United States for a specific purpose?

Ms. STARBUCK. Mr. Chairman, if I may, I will share this response with Dr. Custis.

As you will recall, the Public Law specifically called for medical disciplines to be represented on the committee, and also provided that members of the committee would be former prisoners of war. This committee has met on four different occasions and we will be meeting again the first part of April. I think it has been probably one of the most free-swinging committees.

Their agenda was pretty well set when they came to the first committee meeting. There is a predominance of World War II membership on this, and the groups representing the Bataan and Corregidor defenders, who probably have stronger feelings about the lack of complete and full physical examinations following their release from captivity, brought to the committee an agenda that would cause the Veterans' Administration to bring into existence what was termed a protocol for examinations of former prisoners of war.

That protocol has been established in the Department of Medicine and Surgery. It has received the approval of the committee, and to my knowledge right now is being field tested both with former prisoners of war and with examining physicians.

There were——

Mr. EDGAR. It seems to me, if I could interrupt just a second, that that commission has not been disruptive to the work of the VA.

Ms. STARBUCK [continuing]. No, it has not been disruptive. I think they have been reasonably strident in expressing what they wanted. They have been very receptive to listening to our side of the problem as we view it, and I think we have come to an amicable accommodation in both the medical and the administrative procedures that they have really put upon us.

They come to us with the pleading that, you know, as World War II veterans, as most of them are, they can't wait any longer for us to be about assisting them in a more meaningful way, and they were very concerned about the awareness of individuals in the medical centers and in the regional offices would develop an appreciation of the former prisoners of war experience. We probably put together a training film in record time that has been made available to all our medical centers and regional offices that is used as a training vehicle for our people.

They are in the process now on the committee and will be considering in this next meeting their report to the Congress through the Administrator.

Dr. CUSTIS. I certainly would agree with everything Ms. Starbuck has said. There are just two other thoughts that perhaps might be pertinent to add.

One, the prisoner of war committee certainly isn't one—and I, for obvious reasons, would prefer not to identify the committee the calibur of whose work I would like to reference. But they have taken their congressional mandate as a license for autonomy.

Whereas they could have been much more helpful to us in taking a look at some of the things that are very much in need of evaluation. They chose to do otherwise, giving prolonged attention to something that isn't of such a high priority because it is their conception that this is what Congress would like to have explored and, in the process, have become a terribly expensive committee with their travels. A long time has gone by and a report is yet to be made.

The committee I have in mind is an example of the price we pay some times for the autonomy that is implied with a mandate.

The other thing I would——

Mr. EDGAR. If I could interrupt at that point—I think it might make sense, if you don't want to give that for the record, to at least advise some of the staff, because I think you are going to have before you very soon a legislative process that may move very quickly to establishing a Woman's Advisery Commission. It would be helpful if we knew the nature of the committee that you are referencing. I think I can understand maybe your reluctance.

But it seems to me that what you have stated clearly for us is that the Administrator would like the freedom and the flexibility to do what we want to do legislatively within the VA, that he thinks it is a good idea within the VA to do that.

Dr. CUSTIS [continuing]. There is just a second element that I would add after what you just said, Mr. Chairman. Mr. Walters would prefer that this be a proactive symbol, that he is taking the initiative, that the Veterans' Administration is taking the initiative, and not have, for example, the media say they are doing it because it was mandated.

Mr. EDGAR. I have a couple of additional questions, but I would like to yield to my colleague because I have gone well beyond my 5 minutes.

Mrs. Johnson.

Mrs. JOHNSON. Thank you very much, Mr. Chairman.

I do have a couple of questions that I would like to pose.

You have 136 Readjusting Counseling Service Centers in the Nation, and you refer to the fact that you have several Vietnam era veterans who are women who are serving as team leaders. How many do you have serving as team leaders, and how many women veterans do you have serving as counselors?

Dr. CUSTIS. Mrs. Johnson, we have with us this morning Dr. Ray Scurfield, who is here for the purpose of answering questions on readjustment counseling, and with him is Ed Lord, who has just recently come to Central Office from being a team leader in the field at a Vet Center, and also Dr. Earl Brown, who is the Assistant Deputy Chief Medical Director for all operations.

To get back to your question, there are four female team leaders in the readjustment counseling program, and one of them is a Vietnam veteran. The other three are Vietnam era veterans. There are 29 female counselors in the teams and there are 96 office managers in the Vet Centers, 16 of whom are Vietnam era veterans.

We have no data on the breakdown of male/female among the patients seen in the centers.

Dr. Scurfield, can you add to that?

Mrs. **Johnson**. May I just ask further, of your male team leaders, how many are Vietnam veterans versus Vietnam era veterans?

Dr. **Custis**. There are four female and just one is a Vietnam veteran—Dr. Scurfield, is she a Vietnam era or Vietnam veteran?

Dr. **Scurfield**. She is a Vietnam veteran. Among the counselors, there are——

Mrs. **Johnson**. Excuse me. I was curious of the comparable figures for the male team leaders. How many of the male team leaders are Vietnam veterans versus Vietnam era veterans?

Dr. **Custis**. We can provide that for the record. It is a very high incidence.

Mrs. **Johnson**. My curiosity is the result of the indication that you have just given, that only one of the four women is a Vietnam veteran as opposed to a Vietnam era veteran. Am I misinterpreting that distinction that you're making?

Dr. **Custis**. I see now what you're getting at. You're looking at a ratio, is that it?

Mrs. **Johnson**. Well, I am concerned with the fact that this whole counseling effort was put in place to deal primarily with combat or Vietnam veterans who are having readjustment problems. That would be more in common for those who had been actually in Vietnam than it would be to Vietnam era veterans who might have served stateside during that era.

Dr. **Custis**. Dr. Brown, I would like to hear from you—and I think the Congresswoman would, too. Can you give a little description of what this is all about, the incidence of Vietnam veterans on the teams?

Dr. **Brown**. Let me defer to Dr. Scurfield who has had experience in the field. We do not have an accurate number of male team leaders who are——

We do not have with us the exact number or the ratio of male team leaders who are Vietnam veterans. We would be glad to provide that for the record. Dr. Scurfield can talk about the——

Mr. **Edgar**. If the gentlewoman would yield, we do plan to have a specific hearing, I believe, on March 24, on readjustment counseling. I think, rather than providing it solely for this record, if you could come prepared to that hearing with some information, particularly in a briefing nature for new Members, as to the extent of the program, the kind of counselors, the kind of people involved and how they relate both to men and women within the Readjustment Counseling Center, I think we would adequately answer the question of the gentlewoman.

Dr. **Brown**. We would be glad to, Mr. Chairman.

Mrs. **Johnson**. Thank you.

I am concerned that of the 136, there are relatively few women. I was aware of only the one and, therefore, not aware of three, because of the definitional distinction. It is still a very low ratio.

I see the same subtle disparity between your testimony and what appears to be reality—or what may be reality, I don't mean to make that judgment—between your statements about the adequacy of the VA medical facilities for women, both in terms of facilities and care, and the testimony that we have heard here today which has very strongly indicated a dissatisfaction on the part of women both with facilities and with access to care.

Would you care to comment?

Dr. Custis. I think it is a reasonable conclusion that one draws when one listens to anecdotal instances and without a knowledge of the full perspective.

Incidentally, of our 11,000 physicians, there are something over 900 who are females, employed in the VA system, and one of whom we are particularly proud is Dr. Sue Mather, who is prepared to address the very concern you have expressed just now.

Dr. Mather. I think when one hears anecdotal stories we hear a lot of things, some of them attitudinal, which were addressed earlier; we hear some deficiencies, which we are aware of, which are going to be corrected; and we hear some things that are not gender specific. We hear of some complaints, if you were to take a group of male veterans who were talking about their poor experiences, both inside and outside—there are also non-VA facilities that are fertile ground for horror stories if you are looking for horror stories. So I think we are looking at anecdotes, although there are undoubtedly poor experiences. Not all of them are gender specific.

I think there is, on the part of the Administration, both the agency and the Department of Medicine and Surgery, a great commitment and a desire to see that equitable service is provided.

Mrs. Johnson. I do sense that commitment and desire. I also understand that discrimination in most cases is not intentional, premeditated or hostile. It is simply inadvertent and casual.

You are saying that what we have been hearing is anecdotal testimony, and in your surveys, the information you are being provided by Administrators and by physicians in hospitals, says that they are offering the care. Also, it has become very clear in this hearing that nonservice-connected medical needs of women are met primarily on a fee basis——

Dr. Mather. In nine facilities they are met on a fee basis only. That is true. That is not acceptable to Dr. Custis and it is not acceptable to the VA and that will be changed. It has been ordered.

Mrs. Johnson. In the course of looking into this matter, did you look into whether or not internists who deal with female veterans automatically inquired as to when that person had last had their Pap smear, or automatically provided a breast examination and those kinds of things?

Dr. Mather. No, we did not.

Mrs. Johnson. Because I think that is probably at the heart of the matter. I don't doubt that the physicians are concerned to treat the medical needs of women, but it has been my experience as a consumer, a female consumer, that those questions are automatically asked by internists of me. I had that kind of attention from my gynecologist, so as not to duplicate but, nonetheless, to assure care.

Now, if those questions haven't been routinely asked, that is, indeed, a very serious weakness of the system.

Dr. Mather. I agree. I think there is a misunderstanding here sometimes on the part of the physician, both in the VA and private sector, in that Pap smears are considered preventive medicine. My insurance company will pay for a white-blood count but it will not pay for a Pap smear because that is considered preventive and not a part of medical care.

What Dr. Custis said in his circular is that when you do a complete physical on a VA patient who is female, that will include a pelvic exam and a Pap smear. That clears up, I think, the misunderstanding that has been present. The Pap smear is a part of a complete physical exam and it is not preventive medicine any more than listening to the lungs is preventive medicine, when that is not part of the patient's complaint.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Mr. EDGAR. Dr. Custis, have you determined the makeup of this committee as to female members?

Dr. CUSTIS. Dr. Kinzer?

Dr. KINZER. No, we have made no decision as to that. It would certainly be reasonable and sensible, since we are using as our model the Defense Advisery Committee on Women in the Armed Services, with a predominantly female member and consistently a female chairman.

Mr. EDGAR. Have you determined the number and size of that particular committee as of yet?

Dr. KINZER. The Administrator hasn't made those decisions, but they will be made by the beginning of next week.

Mr. EDGAR. Have you determined how many of those persons on the committee will come from women who served in wartime eras?

Dr. KINZER. The Administrator will make that decision and I can assure you they will be women and women veterans.

Mr. EDGAR. Have you determined how often the advisory group will meet?

Dr. KINZER. It should be from 3 to 4 times a year, which I believe is standard, isn't it, John?

Mr. MURPHY. Three.

Mr. EDGAR. Have you determined how it will be funded?

Dr. CUSTIS. I think the time has come, John, when you should tell us exactly the status of the charter and the formation of this committee.

Mr. EDGAR. Before you begin, I began a speech 5 minutes ago over at the Methodist building across from the Supreme Court and I hope I am very good. I don't mean to cut short our hearing or the hearing process, but I just want everybody to know that I disappear in about 5 minutes.

I yield to the gentleman.

Mr. MURPHY. We are at the point internally where we are about to present the charter to the Administrator, our proposal to him, the proposal from the staffs and departments that are concerned with this area.

Mr. EDGAR. May I interrupt you at that point?

Mr. MURPHY. Certainly.

Mr. EDGAR. How many women have been on the task force to provide those recommendations?

Mr. MURPHY. The task force is inside the agency—well, task force isn't really the proper term. It is through the existing departments and staff. I think a lot of the people you have heard from today were involved in this, I believe.

Mr. EDGAR. How many outside people were involved in that decision?

Mr. **Murphy**. If we used people outside the agency, we would then have an advisory committee and would have to set up a charter to do that.

Mr. **Edgar**. I hope you don't make the mistake that I read about in the business section of today's Washington Post—maybe not a mistake—but a query to the National Traffic Safety Administration, that had a $23,000 consultant hired to write a letter to tell people that their automobiles were defective.

Mr. **Murphy**. We try to do things in-house, when possible.

Mr. **Edgar**. I am not urging you to do them in-house, but I am sure there are some volunteers in the audience who might give the Administrator some advice as to the shape and size and direction of that commission or committee, apart from any legislative agenda that might——

Mr. **Murphy**. From the testimony earlier, I think they already have. I am sure, given the Administrator's views and approach to the whole matter, they will continue to do so and will continue to be invited.

Mr. **Edgar**. I can assure you that the chairman of this full committee and the chairman of the subcommittee and the Senate corresponding committees would appreciate being in the line of communication as you begin to draft your proposals.

I would also say to all of you, I would appreciate, despite your official position on the legislation, making some unofficial comments about the shape and size of the commission and what works or doesn't work. Dr. Custis, in a very clear way, articulated a commission that was established by congressional intent that is causing problems; Dorothy Starbuck raised some positive aspects of the commission that was established by congressional intent. So, through a good one and a bad one, you ought to be able to determine what works and what doesn't work.

I think the idea is to have some outside of the VA input on women's issues, and I think the idea is to make sure that every Administrator, not just this one, cares strongly about women's issues, and I think the idea is that women and others who serve on that commission might offer a different point of view rather than simply doing something that the Veterans' Administration wants. It may be that the advisory commission will do something or say something or offer a report that handles something that the VA needs, not necessarily that it wants. There is always a difference between what you want and what you can afford, what you think is reasonable, and what a commission or advisory group might also want. But I don't think it hurts, as the Administrator is pointing out by his eagerness to set up such a commission, that such a commission exists so that you have that input.

We can argue whether it is administrative or legislative, but it sounds to me like the Administrator likes the idea.

Dr. **Kinzer**. Mr. Chairman, one of the things we should make perfectly clear, so there is no misunderstanding, that this advisory committee will have its members solicited from outside of the VA, both veterans organizations, women's organizations, and women's groups, precisely for those very reasons that you have so admirably stated here today, to get the outside opinions.

Mr. **Edgar**. Thank you. I have no further questions. There will be some questions submitted for the record.[1]

If there are no further questions, this hearing stands adjourned. I would like to compliment all those who participated.

[Whereupon, at 12:40 p.m., the subcommittee was adjourned.]

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[1] See p. 117.

APPENDIX

I

98th CONGRESS
1st Session

H. R. 1137

To amend title 38, United States Code, to establish in the Veterans' Administration an Advisory Committee on Women Veterans.

IN THE HOUSE OF REPRESENTATIVES

February 1, 1983

Mr. Edgar (for himself and Mr. Edwards of California) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to establish in the Veterans' Administration an Advisory Committee on Women Veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) chapter 3 of title 38, United States Code, is amended by inserting after section 221 the following new section:

"§ 222. Advisory Committee on Women Veterans

"(a) The Administrator shall establish an advisory committee to be known as the Advisory Committee on Women Veterans (hereinafter in this section referred to as the "Committee").

"(b) The committee shall consist of—

"(1) members appointed by the Administrator from the general public, including—

"(A) representatives of women veterans;

"(B) individuals who are recognized authorities in fields pertinent to the needs of women veterans, including the health-care needs of women; and

"(C) representatives of both male and female veterans with service-connected disabilities;

"(2) the Secretary of Labor (or a representative of the Secretary of Labor designated by the Secretary after consultation with the Assistant Secretary of Labor for Veterans' Employment);

"(3) the Secretary of Defense (or a representative of the Secretary of Defense designated by the Secretary after consultation with the Defense Advisory Committee on Women in the Services); and

"(4) the Chief Medical Director and the Chief Benefits Director (or their designees).

"(c) The Administrator shall determine the number, terms of service, and pay and allowances of members of the committee appointed by the Administrator, except that the term of service of any such member may not exceed three years.

"(d) The Administrator shall, on a regular basis, consult with and seek the advice of the committee with respect to (1) the administration of benefits for women veterans under laws administered by the Veterans' Administration, and (2) the unique needs of women veterans with respect to compensation, health care, and rehabilitation.

"(e)(1) Not later than July 1, 1984, and not later than July 1 of each second year thereafter, the committee shall submit to the Administrator a report on the programs and activities of the Veterans' Administration insofar as they pertain to women veterans. The committee shall include in each such report an assessment of the needs of women veterans with respect to compensation, health care, and rehabilitation, a review of the programs and activities of the Veterans' Administration designed to meet such needs, and such recommendations (including recommendations for administrative and legislative action) as the committee considers to be appropriate.

"(2) The Administrator shall promptly submit each such report to Congress together with any comments of the Administrator concerning the report.

"(3) The committee may submit to the Administrator such other reports and recommendations as the committee considers appropriate.

"(4) The Administrator shall include in each annual report submitted to Congress pursuant to section 214 of this title a summary of all reports and recommendations of the committee submitted to the Administrator since the previous annual report of the Administrator.

"(f) The committee shall continue in existence until terminated by law.".

(b) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 221 the following new item:

"222. Advisory Committee on Women Veterans.".

SEC. 2. Section 222 of title 38, United States Code, as added by the first section of this Act, shall take effect on October 1, 1983.

PREPARED STATEMENT OF HON. DON EDWARDS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I want to thank you and the members of this subcommittee for the privilege of participating in this hearing. I am proud to sponsor, with the distinguished Chair Mr. Edgar, this legislation for the creation of an Advisory Committtee on Women Veterans. This Advisory Committee would become a permanent committee in the Veterans Administration. I want to commend the Subcommittee for taking up this important piece of legislation early in the session.

We often request a deep commitment from our young female citizens in the defense of our country and way of life. Going into the military, in whatever numbers allowed by the Armed Services, they have always accepted this responsibility with dedication and courage. We, in turn, have a deep moral and tangible responsibility to ensure full recognition and reward for their commitment and service. Establishing this Advisory Committee on Women Veterans is an important step in meeting that responsibility.

The wisdom and guidance provided by such a committee would surely prove invaluable. The committee would enable us to avoid the folly of plannng what's good for others without asking the input of those directly involved. We know that making decisions without input from the affected group can result in policies and programs that are preceived to be malevolent. An Advisory Committee on Women Veterans would help prevent such errors in policy formulation and program implementation for women veterans.

The committee would consult and make recommendations to the Veterans Administration on needed changes, both short-term and long-range, in services and facilities for women veterans. Because of its permanent status, the committee would be able to monitor the progress, thoroughness, and effectiveness of these changes and to advise the VA of needed adjustments.

The committee would serve as a conduit through which Congress, the Veterans Administration, and women veterans can work together to identify the unrecognized needs, unresolved problems, and developing trends among the population of women veterans. This relationship would enable the VA to make necessary changes in a responsive and timely fashion.

A committee of this type has historical precedents. The Defense Advisory Committee on Women in the Services and the Advisory Committee on Former Prisoners of War have proven invaluable to policy makers and the groups they represent. The expertise provided by these committees has raised our consciousness, enhanced our understanding, and greatly improved the quality of our decisions.

With passage of this legislation I look forward to the same experience with the Advisory Committee on Women Veterans.

Despite their valuable contributions to the well-being of the nation, women veterans have, in the past, been our unseen and unsung heroines. The establishment of this Advisory Committee will help ensure that our women veterans are given recognition for their contribution and provided the services to which that contribution entitles them. The establishment of this Advisory Committee will help ensure that our women veterans are accorded the respect and the deep appreciation they so richly deserve.

I welcome the witnesses here today and I eagerly look forward to the testimony presented this morning.

TESTIMONY OF LYNDA M. VAN DEVANTER, NATIONAL WOMEN'S DIRECTOR, VIETNAM VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, my name is Lynda Van Devanter and I am the National Women's Director of the Vietnam Veterans of America. I am honored to testify today before this committee, and to address here, at long last, the needs of our nation's women veterans.

Historically, women who have served this country with pride and honor have not received the kind of credit and recognition to which they should be entitled by virtue of that service. Indeed, they have, in many cases, not even received the tangible veterans benefits which they have earned. It is for that reason we are here today. It is time to correct that injustice, and we ask for the help of the Congress in doing so.

Throughout the fifty-three year history of the Veterans Administration, there has been almost no outreach to women veterans. We can find no posters, brochures, public service announcements which even show a woman as a veteran. Since VVA began the work to achieve recognition of women veterans in the past few years, the first two Veterans Administration studies related to women veterans have finally been done, one in 1981 and one in 1982. Women are still not being included in appropriate research studies of a general nature related to veterans issues. Indeed, the U.S. Government cannot even give accurate statistics on women veterans. For the past four years, VVA has been attempting to learn the number of women who served in Vietnam, and the "guesstimates" have ranged from approximately five hundred to 55,000. With such widely divergent figures being bandied about, one doesn't get the impression that the government knows much of anything about women veterans.

I would like to present here an overview of several of the areas which need to be addressed in relation to women veterans. Those which relate to this subcommittee's work are:

1. Physical medical care.
2. Mental health care.
3. Service connection and compensation for medical conditions.
4. Toxic chemical exposure.
5. Research.

MEDICAL CARE

Over the past few years, VVA has received numerous anecdotal reports from women veterans who have found it difficult, if not impossible, to obtain medical care from Veterans Administration medical facilities. The September, 1982 GAO report on women veterans and the VA indicates that these reports have substance. In most cases, women cannot receive gynecological care from the VA, this being the most elemental health care need of a woman veteran. Two years ago, a directive was sent from Central Office reminding medical facilities that women veterans require specific gynecological examinations as a part of a complete physical exam. Medical centers were told to monitor and review the adequacy of such exams in the directive, yet when the GAO study was done, only one of the medical centers had reviewed charts of women veterans to determine if such exams were being done. In that facility, pelvic exams had been done for only twenty-seven percent of the female patients, breast exams for only forty percent of the female patients, and pap smears for cervical cancer had been done for none of the female patients. This is not adequate care.

And yet, even assuring that such exams are done universally is not the whole answer. There is the matter of having qualified physicians to do the exams. There is also a serious problem with privacy for the women while such exams are being done. There have been numerous reports by women who have noted that physicians who have performed such exams on them were not qualified gynecologists. In some cases, women veterans have been subjected to such exams in full view of men passing through the exam area. Reports have been received of physicians who examined women incorrectly, used gynecological instruments improperly, and showed little sensitivity for the emotional welfare of the female patient being examined. This is not to indict the entire medical professional staff of the Veterans Administration, but too often, qualified gynecologists are not available and older, retired physicians are doing the exams instead. It is important that physicians who are specially trained do such exams. Many diseases of the reproductive system are subtle and are detectable only by careful observation. Women veterans are entitled to receive the best possible care.

VVA recognizes that the population of women veterans is small in comparison to that of men, and it would be difficult to have such well-trained physicians in each and every VA medical center. However, there are a number of options which might be taken in order to assure proper care for women.

1. Establish working agreements with Department of Defense medical facilities to provide such are to women veterans. Most Army, Navy and Air Force hospitals have good gynecological facilities since they treat not only women service members, but also female family members of male service members.

2. Establish working agreements with VA affiliated medical schools and teaching hospitals with gynecological departments. A qualified gynecologist could be available on an on-call basis and/or one day a week, depending on the need for such care.

3. Provide contract fee for service care for gynecological treatment for women veterans. This is supposed to be present already, but there are some significant shortcomings in this program. First, women are seldom informed that they are entitled to such care. Second, fee-basis care is denied to non-service connected female veterans. In almost all cases, care is provided to male veterans regardless of service con-

nection, therefore if this special care is denied women veterans, there is clear discrimination.

In the area of general medical care, there are also problems. Many of the VAMCs do not have proper privacy for women who are admitted to general medical or surgical or orthopedic wards. At times, there are one or two women in a large ward of thirty or forty men. There are no separate shower or toilet facilities, and women must have someone guard the door if they wish to use those facilities. This is sometimes compensated for by having the woman placed in another ward which has better privacy. This is, again, not the entire solution. If a woman who has an orthopedic problem is located on a medical ward, the nursing staff is not familiar with the special equipment, procedures and care of the orthopedic patient. The physicians can forget about the patient since she is out of sight, therefore out of mind. She thus receives substandard care.

While the male veteran population is progressively growing older, the female veteran population, by virtue of the increasing percentage of women in the military is growing larger and younger. The increase will continue, and these issues must be addressed. The GAO report indicates that the VA is not adequately planning for this increasing population.

MENTAL HEALTH CARE

Numerous studies have been done of the mental health needs of male veterans of all eras. Many special programs have thus been developed within the VA to address those needs in the VA's psychiatric facilities. Because women veterans have been so unrecognized for so long, almost no studies have been conducted which either included women or especially addressed their psychological needs. Recently, one study was done by Jenny Schnaier, a project examining mental health adjustment of women Vietnam veterans. This report indicated that women who served in Vietnam do indeed have some specific mental health effects from their service in Vietnam. I would like to submit with my testimony, a copy of testimony from Ms. Schnaier which summarizes her research. It is, as far as we can tell, the first such research which has been done with women veterans. It is our opinion that much more needs to be done, not only with the Vietnam era population of women, but also with other women veterans. In all of the studies of mental health adjustments of veterans in general, women have not been included. Even in the VA's recent, multi-year, multimillion dollar study of Vietnam era veterans commissioned by the Congress and done by the Center for Policy Research, no women were included.

The VA's Operation Outreach Vietnam Veteran Readjustment Counseling Program has, according to the GAO report, begun to address women veterans. This is a very positive step, but there is still much to be done in that program. Recognizing the need, the director of the program, Dr. Arthur Blank agreed to establish a working group on women veterans to the Vet Center Program. That group met in Washington in September of 1982, and produced a report outlining a number of areas which need improvement in the program. The areas include:

1. Therapeutic treatment issues and intervention strategies.
2. Training of counselors within the program to deal with female veterans.
3. Outreach to female veterans.
4. Research into psychological issues affecting female veterans.

Some of the recommendations of the working group are beginning to be implemented, however, work will need to continue in order to assure that women can receive the proper counseling in that program. And other programs of assistance to Vietnam era veterans must be opened to female veterans. Again, according to the GAO report, numerous programs in the VA's psychiatric facilities are not available to women. Of the few in-patient stress treatment programs for Vietnam veterans, VVA knows of only one which has admitted a woman. Certain structured treatment programs for veterans with substance abuse problems and other psychological difficulties are closed to women. In one case, a program is closed to women, and the nearest such program which is open to women is approximately 1,500 miles away. These programs can treat veterans of all eras, and must be available to women as well as men.

The VA has at its disposal approximately $150 million annually in research monies. Almost none of this has been spent on research on women veterans. In fact, the Schnaier study was funded by Vietnam Veterans of America. This kind of research should be the responsibility of the VA. It is mandated to do such work, and it must begin to do so.

SERVICE CONNECTION AND COMPENSATION

Certain illnesses, diseases and injuries incurred by a service member while on active duty are considered to be service connected and thus compensable monetarily and for purposes of receiving medical care by the VA. Because of the fact that women verterans have in the past not been represented within VA, there are instances in which conditions of female veterans have not been declared service connected when corresponding conditions of male veterans have been declared so connected. For example, a male veteran who losses a testicle whether by disease or battle injury, is service connected and compensated for the loss of reproductive capacity. In one case, a woman veteran of fifteen years in the military, had an ovary removed as a result of a tumor while in the service. When she appled for service connection and compensation, she was denied such connection and compensation despite her corresponding loss of reproductive capacity. Her case was appealed and denied the first time. It was then further appealed, and I do not know the outcome at this time. Other such cases have also been reported by women veterans of all eras.

There needs to be an examination of the regulations affecting such service connection, and where inequities exist, they must be dealt with in a fair and equitable manner.

TOXIC CHEMICAL EXPOSURE

In recent years, concern has become apparent that individuals who served in Vietnam may have been exposed to toxic chemicals which may have a long term affect on their health and that of their offspring. The most widely known of these is dioxin, the toxic by-product of Agent Orange, used in Vietnam to deny food and cover to the enemy. The VA has declined to include women in the studies of the effect of Agent Orange on Vietnam veterans. This is totally unacceptable for a number reasons. First, the VA has said that number of women who served in Vietnam is small. To begin with, they do not even know how many women served in Vietnam. At a minimum, there is agreement that there are at least seven to eight thousand women who served there in the military. In government studies on Agent Orange, one is being done with the Ranchhand Air Force personnel, those who directly handled the chemical during fixed wing sprayings. In that group, there are a maximum of 1200 personnel participating. In another study, the VA is studying identical twins, one of whom served in Vietnam and one of whom did not. That group is estimated to be about 400 at the most, and may be as small as 30 or 40. Clearly, the known body of women who served in Vietnam is larger by far than either of these groups.

Second, the VA has said that women would not have been in areas which were sprayed. Simply looking at the HERBS tapes, the computer tapes of the fixed wing sprayings only, would refute that. I have gathered a list of the medical facilities which served in Vietnam and their locations, and comparing that list to the HERBS tapes one can see that those facilities were in areas which were sprayed. Additionally, there is no record of other sprayings such as those from trucks and back packs, and those sprayings were frequently conducted around compound perimeters. It is fairly well accepted that the largest number of women who served in Vietnam were probably in medical positions, therefore would have been stationed in such hospitals and medical facilities. Also, many of the medical personnel, women included, participated in MED-CAPS, the medical civil action programs which took them to outlying villages. Many women have reported going through areas which were defoliated during their tours in Vietnam.

Finally, the EPA and other studies of dioxins have shown that females are more highly susceptible to the reproductive toxic side effects of these chemicals as compared to males. It seems as though there is a "Catch-22" here. If you're more susceptible to the toxic effects, you don't get studied.

We must assure that women who have been exposed to these chemicals are included in studies of their harmful effects. We must also assure that women who may have been exposed to other harmful substances such as the atomic testing of the 1950's are included in studies of those populations. Women must no longer be ignored in these areas.

RESEARCH

As was previously mentioned, the VA has an enormous annual research budget. The agency has not in the past fulfilled its job in including women in research projects. The future holds more women joining the military and the possibility of more women participating in wars. We must not lose the lessons of the past. There is much to be learned from women who have served their country in past wars. We have spent fortunes studying how women in the Army would fare in combat, when we have large numbers of women who have already served in combat. Why have we not studied these women and how they have dealt with war? Women have been injured, killed, psychologically disabled and captured by the enemy. Some sixty-five women were held prisoners of war on Corregidor for years during World War II. Where are the studies of those women? Women have exhibited bravery, strength, and heroism on the battlefield and beachheads. Why have they been ignored?

We believe that the VA should allow a percentage of its research budget to begin addressing women veterans, in many areas: health care, psychological effects both good and bad, effect of imprisonment on women, effect of toxic chemicals and other substances, education and other benefits. If the VA is doing any kind of research, women should be included unless the research clearly eliminates women. In such cases, the question should be raised whether there is a corresponding research need for women. For example, if there is study of testicular cancer in male veterans, consideration should be given as to whether there is a need for study of ovarian cancer in female veterans.

ADVISORY COMMITTEE ON WOMEN VETERANS

VVA believes that one of the most important steps in beginning to achieve some of the goals we have discussed here is to assure advocacy for women veterans with the VA. There must be a voice in the halls of the VA for women veterans to assure that their needs are met and their issues are addressed. For that reason, VVA has been requesting the VA administrators since 1979 to establish an Advisory Committee on Women Veterans which would have the ability to examine appropriate areas, the knowledge to make recommendations for change, and the power to effect implementation of those recommendations and changes. Administrator Cleland at first declined to establish such a panel, then in the Fall of 1980 agreed to do so. When the elections had passed and there was a new administration, he informed us that there would not be sufficient time to establish the committee before the new administration took over. He wrote that he would recommend to the new VA administrator that the committee be established. Upon the installation of Administrator Nimmo in 1981, we approached him, urging again that such a panel be established. He wrote that he did not feel it was needed. In August of 1982, when Mr. Nimmo had the GAO report on his desk, clearly indicting the VA for not addressing women veterans, he changed his mind and decided that there was need for such a committee. Upon his resignation, again we had no committee. Now we have in the person of the new Administrator, Mr. Walters, a supportive voice for the committee. Mr. Walters has agreed to establish the Advisory Committee on Women Veterans, and we are grateful to have, finally, in the agency, a leader who is committed to improving the care and treatment of women veterans. Because of the history, however, we feel it imperative to continue on the legislative course we had begun before his appointment.

Vietnam Veterans of America strongly urges passage of HR 137, the bill to establish the Advisory Committee on Women Veterans. We feel strongly that this issue is important enough that it must not depend on the vagaries of future political appointees to the position of Administrator of the VA. We are pleased that Mr. Walters wants to establish the committee, but we are concerned that a future administrator might decide that he does not feel it to be important. We have already been through three different administrators and five different answers on this issue. We believe that the need for an importance of this comittee has been clearly established, and we ask the Congress to assure its implementation and continuation.

CONCLUSION

Throughout the history of the United States, women have volunteered and served their country. They have stood side-by-side with their brothers in that service. They have kept faith with their brothers and their country. The country and the government have, sadly, not kept faith with them. It is time for women veterans to stand tall beside their brothers and receive the recognition and credit they are due for their service. It is time for them to receive the benefits they have earned by their service.

Thank you for the opportunity to present the views of Vietnam Veterans of America on this important subject.

PREPARED STATEMENT OF SARAH MCCLENDON, WHITE HOUSE CORRESPONDENT

Gentlemen and ladies of the House Veterans Affairs Committee: my name is Sarah McClendon, and I am attempting here to speak on behalf of all women veterans from all branches of military service of the United States.

We need equal facilities for women veterans in veterans hospitals and all facilities. Present service must be improved.

The United States in the future will have an increase tenfold in the number of women veterans. Therefore, veterans' hospitals can be expected to have to provide services for more women patients.

I am basing the prediction of increased numbers on the fact we have today 180,000 women in the peacetime armed forces. This strength is due to be increased by the Reagan administration to 210,000 on active duty. Heretofore and after World War II, the number of women veterans was less than 2 percent that of the men, but now it is going to be 10 percent.

Today, women serve in highly technical and strategic jobs throughout the world with U.S. units in Europe, the Middle East, the Far East, India, South Korea. Their performance puts them in exposed positions. Often they hold blue collar jobs where the accidents rate is high. These factors are sure to increase the number of women patients in veterans hospital in the future.

My qualifications as a spokesperson for women veterans stem from the fact I have studied these problems since 1943. I am a veteran of the Women's Army Corps in World War II where I was a spokeswomen for the WAC, the Army, and the Army Surgeon General.

I have visited many military and veterans hospitals and have dealt with many veterans' problems, at their request.

As for military women, I served on the Defense Advisory Committee on Women in the Services for three years and, by invitation, maintain current information as to problems. I also was designated by the Chief of Staff of the U.S. Army to serve on a committee of women studying women on active duty for the Army's Policy Review. I am presently studying ways to expose and correct federal laws and regulations that are written to discriminate against women.

I want to support strongly your attempts to expand the services for military women veterans in VA hospitals. I commend this committee for giving women this chance to be heard. And I support HR 1137 to create a women's advisory committee for the Veterans' Administration. They need this. I believe the new VA head, Mr. Harry Walters, is to be commended for his initiating this idea of an advisory group, long wanted by certain veterans groups, and for his expressed interest in improving facilities for women.

The construction, staff and management at Veterans Hospitals should be greatly improved, based on the findings of the General Accounting Office, with some notable additions.

Let me suggest that in future when you commission a survey of veterans' hospitals that you include women veterans.

I am not satisfied with the comments of the Veterans' Administration of the General Accounting Office draft report of July 21, 1982, Enclosure III, page 23. One finds there no specific promise to produce better service, only bureaucratic doubletalk, such as "VA will develop guidelines to assist... in improving access to outpatient gynecological care." That is what we have now.

The VA says it "will provide the special facilities needed for the treatment of a female veterans when the VA's health care programs require these facilities." Well, the time is NOW!

Continuing, the VA says "interim solutions are often necessary even though they require a compromise in program scope and staff convenience." Well, I think we need a translation to know what they mean but I detect that they are saying it will still be necessary for Master Sergeant Gabriella Gouveia of Arlington, Va., and friends to make their own handwritten signs that read: "Women Taking Showers," and affix these to the doors in veterans' hospitals.

As to the future load that we can expect in the way of more women patients, let me point out that we had 5700 women serving in all branches of the services in Viet Nam. That is according to Maj. Gen. Jeanne Holm, USAF, Ret., who has just researched the matter for her excellent new reference book, "Women in the Military." In addition, we still have many women veterans from the 350,000 women who served in World War II. According to Nancy Hoar, national president of the Women's Overseas Service League, we still have 100 women veterans living from World War I.

I believe we can expect a lot more women patients from the large number of women who served in the South Pacific in World War II, where the hardships created chronic health problems. There, the women lived in tents, fought dozens of rats nightly and musquitoes, developed malaria and other diseases, had no solid food for months, had to endure long hours and no recreation or exercise because the enemy's soldiers were always to close. The Army boot given them rotted on their feet in that damp climate.

When you look at the jobs women perform today, you can see we are goint to get more patients. They serve as jet engine mechanics, Tank Turret repair technicians, do refueling of aircraft in the air, refuel tankers, fly helicopters and C-141 planes, ferry passengers and cargo to Naval air carriers at sea, jump as paratroopers, serve on destroyer and submarine tenders, operate with air evacuation teams. They serve in most of the jobs offered in the military, with few exceptions.

Because of the economic situation, when there is a financial squeeze in government and private industry, women are usually the first fired and they often get paid far less than men for the same or comparable duties. This means we can expect that more of those women veterans will have to call on the Veterans Hospitals for care.

I am asking that the VA alert contractors in future to make sure that hospital facilities include necessary accommodations for women. In the past, these contractors have taken the taxpayers' money—and VA inspectors have let them get by with it—without thought for women. They did not even provide a shingle to be hung on doors to restrict showers temporarily.

Nor are patient rooms equipped with sufficient bathing facilities. Men patients as well as women some times have to brush their teeth over the bathtub. Even bathtubs are not always provided for patients' rooms. Sergeant Gouveia had to take a sponge bath for two weeks.

Rooms are often cold. The boiler does not always seem to work at that big expensive hospital in Washington, D.C. And that situation is not good for heart patients. Sergeant Gouveia once was ordered to the hospital. In fact, they sent an ambulance for her. But after she arrived, it took hours to get her into a room and then it was cold.

Daily physical therapy, if required, is not possible for women. There is no self help ward. Often women patients are sent home to care for themselves if they live alone, but there is more room for men patients, even if they are ambulatory. Sergeant Gouveia was told to go home and stay in bed except for trips to the refrigerator. She lived alone. What about hot meals?

Women Army Corps veterans in the Washington area according to Georgia Sorrells, president of Chapter 16, report a woman cancer victim who was terminal was sent home two months before death.

There should be gynecologists on the staffs, readily available. When special paper work is required and a hand-out allowance given women to go find their own private doctor, this could mean delays in examination and treatment. Now strongly protesting this condition which she thinks exists throughout the nation is Ann Pace, resident of a veterans' home in Yountville, Calif. She feels her cancer of the uterus could have been prevented or at least corrected with radioactive treatments. But she was months too late when she reached the gynecologist. The treatment and doctor should be readily available for this need that could involve many women veterans.

Many women veterans who are retirees feel they get better care when they go to Army or Navy hospitals. Sergeant Gouveia did when Walter Reed diagonosed her injured shoulder as broken after the VA hospital said there was nothing wrong. But all women veterans are not retirees, and thus such facilities would be denied them.

You can see, that women, like men veterans, have earned their right to receive fully adequate care. Thank you.

WOMEN'S OVERSEAS SERVICE LEAGUE,
OFFICE OF THE PRESIDENT,
Arlington, Va., February 26, 1983.

MRS. SARAH MCCLENDON,
28th Street, NW.,
Washington, D.C.

DEAR MRS. MCCLENDON: The most inhumane treatement of a patient by the Veterans Administration which has recently come to my attention is the reported experience of one of the late members of the Women's Overseas Service League in California. This is a second-hand report; I did not know the member and am repeating which I have been told.

Mrs. Dorothy Hushing lived in Palo Alto, California. She had served as a nurse overseas with the Air Force Nurse Corps in World War II and was accorded vetertan status based on that service. She was a divorcee approximately 60 years old when she developed cancer and received treatment at a VA hospital near her home. She was given in-patient primary treatment at the hospital, but the VA refused to continue care after it became evident that her case was terminal. She had little or no means to pay for nursing care, no strength to work and earn care, no family to assist her. She was discharged from the VA hospital in very serious condition and survived only a matter of weeks.

If you need more detail, I refer you to a past national president of the League, Miss Nelva M. Gillette, 3015-190 Bayshore Boulevard, Redwood City, CA 94063. Miss Gillette visited Mrs. Hushing in the hospital, I understand, and helped with her later care.

Sincerely,

NANCY H. HOAR,
National President.

STATEMENT OF JUNE A. WILLENZ, AMERICAN VETERANS COMMITTEE

Mr. Chairman and members of the subcommittee; it is a great privilege for me to present the American Veterans Committee testimony in support H.R. 1137, a bill to establish an Advisory Committee on Women Veterans in the VA. My name is June A. Willenz, and I am the Executive Director of the American Veterans Committee.

We commend Congressman Edgar for introducing this important legislation, and also Congressman Edwards for cosponsoring it. The American Veterans Committee (VAC) has been seeking the creation of such an Advisory Committee on Women in the VA for over three years. This legislation is very timely and we support it wholeheartedly.

BACKGROUND

Our suggestion that the VA needs an Advisory Committee on Women grew out of the findings of AVC's Special Project on Women Veterans in the late seventies that women veterans were a 'forgotten population.' That project worked under the guidance of a prestigious committee of social scientists.

The Project conducted an exploratory investigation and found there was almost no historical data on women veterans' use of veterans programs, and there was no systematic current data-keeping. The lack of historical data on the use of veterans benefits programs administered by the VA arose from the fact that the VA only kept a 2 percent sampline of its historical records. Since women were less than 2 percent of the veterans population until the 1970's when women's participation in the armed services increased dramatically, women veterans did not appear in the sample. As a reslult, there is not way of knowing how women veterans of World War II used their GI bill benefits or any other benefits.

The Project also found that there was only sporadic data keeping on women's use of veterans benefits programs; on several, on data was kept at all. Other programs administered by other government agencies, i.e., Department of Labor, HHS, or OPM, were equally deficient in data keeping on women veterans. Generally women veterans were lumped together in the general veterans population or omitted altogether.

Another striking fact was that studies and reports were leaving out women veterans. No substantive social science research was being done on women veterans, either in the academic or private research community. For example, the National Academy of Science study in 1977 of the health-care system stated in its preface: "In this analysis, only male veterans are considered because the female veterans amount to less than 2 percent of the current total." In the 600-page response to the NAS report by the VA, that volume also did not include women veterans.

Another important study conducted by the census Bureau (1979) for the VA was entirely male-based. Purpose: "to collect information that . . . determine the effectiveness of veterans benefits programs in meeting the needs of the nation's veterans and to provide a basis for future planning of programs and facilities." In such a sizeable sample—11,000—women veterans certainly could have been identified and included, but they were not.

The overall picture is one that government agencies viewed women veterans as an insignificant population because it was a small group compared to the male population.

The 1980 Census is the first time that women have been queired as the their veterans status. That Census found that there are 1,108,000 women veterans, representing 3.8% of the total veterans population. This is a considerably higher figure than the approximately 742,000 previously cited as the official number.

Women veterans around the country hearing about the AVC Project have reported their lack of knowledge and lack of use of benefits programs. The Project also received many reports of failure to obtain timely needed health care services from the VA hospital system, of bureaucratic run-arounds, and staff insensitivities. Problems of inadequate physical examinations, lack of privacy and convenient bath and toilet facilities for inpatients were also bought to the AVC Project's attention. The recent GAO Report has confirmed and elaborated on these patterns of deficiencies in the VA hospital system for its women clients, both as in- and out-patients.

HISTORY OF AVC PROPOSAL

The AVC shared its findings with the VA and suggested that the agency and the public interest would benefit greatly from an "advisory panel on women" at the VA. We pointed to the continuing important role that the Defense Advisory Committee on Women in the Services (DACOWITS) has played relative to the concerns of military women with the Secretary of Defense.

Three years ago, in a letter to then-VA Administrator Max Cleland, AVC recommended that a "VA Advisory Panel on Women" be created that would:

"1. Review policies and programs relating to women veterans, and make recommendations to the VA Administrator concerning such policies and programs.

"2. Provide advice to the Administrator on any matters concerning women veterans which the VA Administrator or other authorized VA officials refer to the Panel.

"3. Initiate suggestions for improving outreach and information about benefits programs.

"4. Serve as a channel through which women veterans may transmit their views and recommendations to the VA."

The dialogue with the Administrator on AVC's suggestion continued through his tenure as Administrator. Despite his positive feelings, Mr. Cleland deferred the decision to his successor, Mr. Nimmo. While Mr. Nimmo was initially negative, he was seriously considering the proposal at the time he left the Agency.

We are pleased to report that the present Administrator, Mr. Harry Walters, has assured us in a meeting we had with him on January 14th that he is going to establish such an advisory committee. We wish to take this opportunity to commend him for his statement of intention.

However, we believe that the role of the VA Advisory Committee on Women will be enhanced by having Congress also endorse the Committee by enacting this legislation. Congressional commitment to the importance of such an independent advisory group that will concern itself solely with the problems and needs of women veterans will be reassuring to women veterans.

Attached to this statement is the memorandum we presented to Administrator Walters on the Advisory Panel of women veterans.

WHAT ARE SOME OF THE PROBLEMS

The problems facing women veterans in our society have not been reviewed, surveyed analyzed or evaluated. But we know from reports from women veterans all over the country who have sought to use the VA health-care system that there are serious deficiencies and gaps in treatment and services. The GAO Report confirms these reports.

Since the VA health care system was set up primarily for those hurt and diabled in combat, it is not surprising that little attention was paid to the making the institution responsive to the health needs of women veterans. They were not supposed to be in combat. Yet many women have sustained service-connected disabilities and injuries.

That fact was addressed by a unique entitlement in Title 38-601.4(c) which states that a woman veteran must be provided care in a private hospital if she cannot get proper care in a VA hospital or if she lives too far. However, this entitlement to private hospital care is only for a service-connected illness or injury.

What has happened to the women with non-serviced connected illnesses or injuries? They theoretically should have the same access to treatment, or an in-patient and out-patient basis, that men do. This has not been the case for several reasons.

One is based on the institutional inability to provide gender-related care and treatment. The VA has only seven full-time gynecologists on staff for 160 facilites. Those kinds of health-care services, if service connected, can be contracted out or provided for on a fee basis.

But for those with non-service connected gender-specific health problems, there is no provision for non-VA care on a contract or fee basis. There have been horror stories of women veterans with acute conditions being told to come back six months to a year later. Legislation to provide fee-basis care in such circumstances should be seriously considered.

Many non-service connected illnessese and complaints of male veterans are treated on an out-patient basis. The GAO Report indicated that in 1980, about 89 percent of the male inpatients were treated for non-service connected disabilities.

If indeed the VA health-care system is intended to be responsive to the health-care needs of all veterans, non-service connected as well as service-connected, then in must provide the same services to its women veterans. "An beware the specious argument that some who the non-service connected veteran, the medically needy non-serivce connected veteran is not entitled to care in the system. The system cannot exist caring only for service connected."—Dr. Donald Custis.

Besides the staffing deficiencies, women veterans have complainted of lack of privacy and inadequate bath and toilet facilites. Such deficiencies, we understand, will be taken care of in the plannng of new and future facilities. However, there must be immediate planning and resources allocated to correct these inadequacies in the older facilities if indeed women veterans health needs are to be met.

Other areas of staff insensitivity and brusqueness have contributed to the preceptions of many women veterans that they are not welcome at VA facilities. A recent statistic from the VA reveals an average of 1.7 percent females in VA medical facilities among approximately 77,000 veterans patients.

Other areas that needed to be addressed are the specific emotional and social dysfunctioning of the women who serve in the Vietnam-era. They, too, have suffered from the PVS (post-Vietnam Syndrome). Just as society and the VA have lagged in recognizing and treating this ailment, they have not acknowledged the conditions that women veterans have suffered as a result of the peculiar circumstances and trauma of that war.

It is incumbent upon the VA to give systematic and dedicated attention to meeting those "health" needs of this group of women veterans.

We are pleased that the VA has begun to address these deficiencies and look forward to their continued progress and commitment. An Advisory Committee on Women would serve a very useful function in pinpointing the problems areas and channelling women veterans concerns to the Administrator.

Since the AVC Project on Women Veterans found a dearth of data and reporting on women veterans, we had recommended that in order to meet the needs of women veterans, it was necessary to develop a profile of those veterans and to ascertain their utilization of benefits.

We are pleased that VA's Office of Reports and Statistics has released three reports on women veterans: "Women Veterans: Use of Educational Benefits of the GI Bill (September 1981)"; "Statistical Brief: The Female Veterans Population: An Overview of Its Groth in the Last Decade (March 1983)"; and "Women Veterans Usage of VA Hospitalization (August 1982)." We understand that there are other VA reports in progress on women veterans. AVC suggested to the VA years ago that a comprehensive in-depth scientific study of women veterans was needed. We suggest such a study is still needed.

With further reference to the GAO Report's recommendations, we were pleased that then-Administrator Nimmo responded positively to the main thrust that VA health-care facilities needed to be upgraded and updated in order to provide female veterans access to out-patient gynecological and other care not available at current facilities. Furthermore, the Administrator agreed to develop projections so that the VA will be prepared to accommodate women veterans' health-care needs. Those projections should also take into account the long-term care needs of women veterans, which to date are practically not being met at all.

We were disappointed that the Administrator did not agree to do any kind of evaluation of female veterans awareness of benefits nor to establish procedures to insure that female veterans are notified of major changes in veterans benefits that affect them. We hope that the present Administrator will review those recommendations and reconsider the VA's position.

CHALLENGES AHEAD

The VA's Brief on the female veteran population poses some of the important challeges to the VA system. The female veterans population is increasing at a faster percentage rate than the male veterans population and its is an increasingly younger population. While the male veterans median age is getting older, that of the female veterans is getting younger.

The median age for female veterans has dropped fom 50.5 years to 46.2 years from 1977 to 1981. For male veterans, the median age has risen from 45.1 years in 1970 to 50.3 in 1981. The increased number of women in the military services in the mid-seventies accounts for the demographic shift which is expected to increase futher in the 80's, although at a slower rate. hence, it is to be assumeed that the median age will drop even more in the years to come.

This means that the VA hospital health-care system if it is to meet its understanding of its mandate to provide health-care for the nation's veterans, will have to provide for the health needs of an increasing younger female population. Many of those needs are gender-specific.

The VA system also has to meet the challenge of the large aging World War II veteran population who will become eligible for all the services of the VA health care system afer they turn 65. Among this group are the women who served in World War II, still the largest group among the women veterans.

These older women veterans have hardly used the resources of the system for a variety of reasons. But it is to be expected that as they get older, they will require more domiciliary and long-term care, as well as acute care facilities. To date, the VA has not made systematic provision for domiciliary and nursing home care for women veterans. That is a major need that will require planning and resources.

The concluding statement of the VA's report on Women Veterans Usage of VA Hospitalization poses the problem: "The available data on women veterans usage of VA hospitalization benefits show that the number of women beneficiaries of VA hospitalization benefits is growing. This trend is expected to continue. The immediate demand for hospitalization occurs among young women veterans but, in the long run, demand for medical services will be increased among older women veterans as well. However, the lack of data on women veterans precludes any attempt to clarify specific future requirements in terms of services and suggests the need of an examination of patterns of use in the population which is to be served. Such information cannot be obtained from those sources currently available within the VA."

An Advisory Committee on Women Veterans is needed today if the VA is to provide equitable treatment and services to its women veterans.

At a recent conference on the role of Federal Advisory Committees, it was suggested that "the advisory committee system is perhaps the most under-utilized network linking government and citizens."

In view of the neglect and omission, often not deliberately, of women veterans from the service delivery system and programs specifically for veterans, an Advisory Committee would be most desirable. It would give women veterans a sense that their needs are important and being addressed by "a grateful nation." "Citizens working with government professionals, have helped to shape policy, to advise on scientific and social research and sometimes to build a consensus among conflicting viewpoints."—Statement from Kettering Report on Federal Advisory Committees.

Women veterans served honorably and with dedication in the armed forces of this nation during wartime and peacetime. They volunteered for military service when they were needed and did themselves and their country proud. They did not shirk any task that was asked of them. Some were injured; some were taken prisoner; some developed illnesses and diseases as a result of their service.

This nation owes a similar debt of gratitude to its women veterans as to the men who served. Veterans benefits indeed must be as available, accessible and relative to the needs of women as for men.

To meet its commitment to the women veterans of this country, it is essential that the VA take urgent and immediate steps to be responsive to the health-care and other requirements of this significant group of more than a million veterans. An Advisory Committee on Women Veterans would provide invaluable input to the VA Administrator and his policy planners as they act to meet that commitment.

We urge this subcommittee to report out favorably H.R. 1137 as an important step to recognizing the needs and problems of this nation's women veterans.

AMERICAN VETERANS COMMITTEE PROPOSAL FOR A VA ADVISORY PANEL ON WOMEN (VAPOW)

We suggest that the VA set up an advisory committee on women veterans under the terms set forth by 5 U.S. Code Appendix Section 1 (Federal Advisory Committee Act of 1972). This committee should be at the Administrator's level.

Such a committee is necessary at this time for the following reasons:

1. The increasing number of women veterans identified by the VA, with an upward trend of younger women veterans in the years ahead.
2. GAO Report identified problem areas in the VA hospital system for women veterans. Also, the GAO did not review the other programs. VA reports also have shown problem areas within the VA medical programs.
3. Historically, the VA has little data on women veterans. It is important to gather as much current data as possible. This committee would facilitate such data-gathering.
4. There have been no information programs or outreach efforts targeted to women veterans.
5. There has been no survey or evaluation of what benefits women veterans have found useful, or what they might find useful. Also, there have been no studies on whether women veterans are knowledgeable about their benefits and rights.
6. An advisory committee could serve as a useful independent channel through which women veterans could make known their concerns and recommendations.

We suggest that there be approximately 30 individuals on the Committee. They would be appointed by the Administrator who will call upon women veterans groups and veterans organizations for their suggestions.

Two-thirds of the Committee should consist of women veterans and from veterans organizations with a strong interest in women veterans. The other one-third should be experts in fields relevant to women veterans concerns: medicine, social work, employment, education, business, etc. Representatives of all the VA departments would be members ex-officio. Provision for representatives of other concerned government agencies such as the Department of Labor, HHS, or OPM, or DOD to join in the meetings will be made.

The Committee should meet at least four times yearly and will prepare an annual report for the Administrator.

There should be appropriate staff support to assist the committee in carrying out its functions.

DEPARTMENT OF DEFENSE,
DEFENSE ADVISORY COMMITTEE
ON WOMEN IN THE SERVICES,
Washington D.C., January 30, 1980.

MS. JUNE A. WILLENZ,
Executive Director, American Veterans Committee,
Washington, D.C.

DEAR MS. WILLENZ: The Executive Committee of the Defense Advisory Committee on Women in the Service has voted unanimously to endorse the Women Veterans Project being undertaken by the American Veterans Committee. We agree with the premise upon which the project is based; that the 650,000 women veterans is a significant but overlooked population of our Nation, and that there is a need both for research and advocacy for this group.

The Committee hopes that you will keep up advised on the progress of the project.

Sincerely yours,

SALLY K. RICHARDSON,
Chairperson.

DEPARTMENT OF DEFENSE DIRECTIVE ON DEFENSE ADVISORY COMMITTEE ON WOMEN IN THE SERVICES

(References: (a) DOD Directive 5120.14, subject as above, July 13, 1962 (hereby canceled); (b) DOD Directive 5000.19, 'Policies for the Management and Control of Information Requirements," March 12, 1976; (c) DOD Directive 5000.11, "Data Elements and Data Codes Standardizaton Program," December 7, 1964; (d) DOD Directive 5105.18, "Department of Defense Committee Management Program," April 25, 1975.)

A. REISSUANCE AND PURPOSE

This Directive reissues reference (a) to conform with current DOD policy, and establishes the organization and staffing structure of the Defense Advisory Committee on Women in the Services.

B. APPLICABILITY

The provisions of this Directive apply to the Office of the Secretary of Defense, the Military Departments, the Organization of the Joint Chiefs of Staff, and the Defense Agencies (hereafter called "DOD Components"). The terms "Services" and "Military Services," as used herein, refer to the Army, Navy, Air Force, Marine Corps, and the Coast Guard (by agreement with the Department of Transportation).

C. ORGANIZATION

1. Pursuant to the authority vested in the Secretary of Defense, there is hereby reconstituted within the department of Defense the Defense Advisory Committee on Women in the Services (DACOWITS).

2. The Committee shall be composed of approximately 30 civilian members, selected on the basis of equitable distribution of fields of interest and geographical representation. Members must be U.S. citizens, and shall be selected without regard to race, creed, sex, national origin, age, marital status, or physical handicap.

3. Members shall be appointed by the Secretary of Defense and shall serve as individuals and not as official representatives of any group or organization with which they may be affiliated. The term of membership is 3 years, with approximately one-third of the membership rotating annually.

4. The Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics) (ASD(MRA&L)) shall designate annually a member of the Committee to serve as Chair.

D. FUNCTIONS

The Committee shall:

1. Provide the Secretary of Defense, through the ASD (MRA&L), with assistance and advice on matters relating to women in the Services, and recommend measures to ensure effective utilization of the capabilities of these women. In this connection, individual Committee members or groups of members may be called upon to serve on task forces covering issues such as recruitment, training, utilization, housing, health, and welfare.

2. Interpret to the public the need for and the role of women as an integral part of the All-Volunteer Force; encourage public acceptance of military service as a citizenship responsibility and as a career field for qualified women; and provide a vital link between the Armed Forces and the civilian communities.

E. ADMINISTRATION

1. The Committee reports to the ASD(MRA&L), with functional responsibilities under the staff cognizance of the Deputy Assistant Secretary of Defense (Military Personnel Policy) (DASD (MPP)).

2. The Committee shall meet at the invitation of the ASD(MRA&L). A minimum of two formal meetings shall be held annually, and the presence of a majority of the members shall constitute a quorum.

3. The ASD(MRA&L) shall provide such personnel, facilities, and other administrative support necessary for the performance of the Committee's functions.

4. The DACOWITS Secretariat shall be directly responsible to the ASD (MRA&L), and shall function under the direction of the DASD(MPP), Office of the ASD(MRA&L), in providing the necessary assistance and support services for the conduct of the Committee's business.

5. In carrying out the functions stated herein, the Committee may obtain information, consistent with the provisions of DOD Directive 5000.19 (reference (b)), and assistance through the Secretariat from the DOD Components. Existing DOD standard data elements will be used for all information requirements, when possible, in accordance with the provisions of DOD Directive 5000.11 (reference (c)).

6. The Chair of the Committee shall submit annually a written report to the Secretary of Defense on key issues relating to women in the Services.

7. The members of the Committee shall serve without compensation, but may be allowed transportation and per diem instead of subsistence and other expenses.

8. The policies, rules, and procedures contained in DOD Directive 5105.18 (reference (d)) apply to this Committee.

F. EFFECTIVE DATE

This Directive is effective immediately.

STATEMENT OF JENNY ANN SCHNAIER

Mr. Chairman, and Members of the Committee. I am honored to be here to testify before the Subcommittee on Hospital and Health Care on the issue of women veterans. I am Jenny Schnaier and the purpose of this testimony is to present the results of my research study on women Vietnam veterans which was conducted for my Master's thesis at the University of Maryland. Due to the length and complexity of this research effort plus the other testimony to be presented before this committee, I will give only a very brief overview of my research which will include some background information on women Vietnam veterans, a description of the study, and a presentation of the conclusions drawn. I have brought with me a copy of the entire text which I would like to offer this committee, not as part of the record, but to provide any further information you may desire. I will begin with a brief background of the issue.

BACKGROUND

In the past several years, increasing attention and interest have been focused on the psychological and readjustment effects of the Vietnam war on the women and men who served there. The personal, social, and historical legacies for male veterans of that war are being addressed in formal and informal research efforts, professional conferences, in veterans outreach centers, in the popular literature, and in committees such as yours.

Recent mental health research has revealed seemingly negative consequences for veterans in their readjustment processes. Among the most prominent of these discoveries is that many Vietnam veterans suffer from one of the several forms of Post-Traumatic Stress Disorder (PTSD), an anxiety disorder caused by severe and externally induced stress. One group that these research efforts have neglected to address in their studies is the approximately 8,000–10,000 women who served their country in Vietnam, often on frontline zones and mostly as medical personnel.

Who are these forgotten women? It is very difficult to say. Current research and available statistics do not cover female veterans. The Government has no listing of who these women are, nor the capacities in which they served. They do not systematically collect statistics on gender and military service. Neither the Bureau of Labor Statistics, The Office of Personnel and Management, nor the 1979 Census Survey collect data on women veterans. Any statistics that do exist are estimates based on various other indicators such as the number of medals awarded. Most of the preliminary and informal studies show that a majority of these women were nurses and many served on the front lines in M.A.S.H. type facilities.

Despite this lack of information, a review of the popular literature on female veterans reveals unrelenting experiences of constant casualties, mangled bodies, 24-hour work shifts, war-time romances ended abruptly, necessity of immediate, God-like medical decisions about treatment, and a daily experience of the death of young boys (the average age of combatant was 19.2 years old) who were at the prime of their physical development.

These veterans report that their roles as women and nurses in the war were complex, ambiguous, and guilt ridden. In the days before their military service, they acted in the ways they had been raised and medically trained—feminine, nurturing, altruistic, passive, and reactive. In the space of a few days following their first assignment, they were far from anything remotely feminine and were called upon medically to be assertive, active, and in charge. In short, they experienced a complete role change almost overnight. The women report having trouble maintaining both their strength and their femininity. When the women got angry, they were not as able to release it as men did through the use of weapons, physical violence, or drunkenness. Because there were so many fewer of them, women felt more isolated than men did. While men and women may have been seeing the same war, women veterans appear to have brought with them their own distinct background and coping strategies for their service in Vietnam.

As stated earlier, until now there have been no scientific research inquiries into women Vietnam veterans, their experiences, nor their mental health adjustment that this researcher has been able to locate. All that is known stems from those self-reports and anecdotal evidence just discussed which suggests that women veterans' experiences in Vietnam and their reactions to them are similar to those of male veterans (even if their coping strategies are not) and the now emerging self-descriptions of stress symptoms indicate they too may be suffering from PTSD.

The intention of my research project was to assess the nature and extent of mental health problems, specifically PTSD, affecting female Vietnam veterans in the research design of a descriptive, preliminary study. It was also intended to ascertain if these experiences and reactions were restricted to a few vocal women, or whether, they were similar to the male veterans who, previous research has shown experienced a wide range of psychological readjustment problems, the most common of which is PTSD.

POST-TRAUMATIC STRESS DISORDER

PTSD is the most common reaction of veterans exposed to war, although research has shown it to also be a reaction to such extraordinary events as explosions, hurricanes, floods, major fires, and airplane accidents. Of most interest to this committee and our purpose here is its linkage specifically to the stressful military combat experience. It is not precisely clear how many veterans are suffering from this disorder, but estimates of acute, chronic, or cyclical PTSD incidence range from 700,000 to 800,000 or about 40 to 60 percent of all male veterans.

Until the 1980 revision of the Diagnostic and Statistical Manual of Mental Disorders III of the American Psychiatric Association appeared, there was no formal diagnostic category for PTSD. It is now however, classified as a special form of an anxiety disorder. The diagnostic criteria for PTSD include (a) existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone, (b) re-experiencing of the trauma, (c) numbing of responsiveness to or reduced involvement with with the external world, beginning some time after the trauma, and (d) various reactive symptoms including excessive autonomic arousal, sleep disturbances, guilt about surviving, memory impairment or trouble concentrating, nonviolent impulsive behavior, and substance abuse. The disorder can range from mild to severe and in its most extreme forms can affect nearly every aspect of life. Although symptoms often occur immediately following the trauma, it is not unusual for emergence to occur after a latency period of several days, many months, or even several years after the original trauma. PTSD can be diagnosed as acute, or chronic or delayed.

STUDY DESCRIPTION

Through a mailing list of the Vietnam Veterans of America, 89 women Vietnam veterans who had served in medical positions in Vietnam completed a written questionnaire in a mail out survey which produced a return rate of 97%. The survey included sections about their biographical and demographic background, their experience of stressors while in Vietnam, their current stress symptoms and incidence rates, a temporal rating of stress symptoms and their possible dates of onset and resolution, and about their general feelings about and reactions to their Vietnam experience.

LIMITATIONS

It is important to remember that this study was designed as a preliminary, descriptive inquiry into the lives and experiences of women veterans. In the beginning stages of any new research effort as much information as possible must be gained in order to help direct and focus future studies to come. The limitations inherent in this type of research such as, no comparison group to whom the findings can be compared and the inability to obtain a truly randomized, non biased sample suggest that it would be irresponsible to make any broad generalizations about the results observed. Any findings made, or conclusions drawn can only speak about this particular sample group and their characteristics specifically. This is not to minimize the importance or significance of what was observed, because it stands as a very sound and important research project, but rather my attempt to insure that the desire for information about women veterans and readjustment does not lead us into using the preliminary findings inappropriately. Having conveyed this, let me address the conclusions and implications of this research.

CONCLUSIONS

This research has provided preliminary evidence that Post-Traumatic Stress Disorder may be applicable to the experiences of women Vietnam veterans.—The instrument employed in this study has been found to be both reliable statistically, and valid in that there was a significant correlation between stressors experienced in Vietnam and PTSD symptoms for this sample. The highest identified stressors of their Vietnam experience (involving nursing duties, experiencing shortages, continual streams of casualties, negating emotions, and seeing the mutilation of young bodies) together with the types of symptoms identified by the women veterans which are associated with PTSD, support the notion that further studies are indicated and justified to look more closely at women Vietnam veterans and their mental health adjustment. Approximately one-third of the PTSD symptoms were identified by 25 percent or more of the subjects as presently occurring between ten and thirty times a month. These identified symptoms represent a fairly complete picture of those specific symptoms and experiences of PTSD as defined by the Diagnostic and Statistical Manual III (1980) by the American Psychiatric Association. Any new research efforts will have an open field to explore because so much is yet unknown and needs to be tapped.

Second, this research has found that there is evidence of mental health distress among the women sampled.—When asked about symptoms during the past six months the following was observed: 27.6 percent reported having suicidal thoughts between one and nine times a month; 19.5 percent reported feeling alienated from other people between 15 and 30 times a month; 19.2 percent reported feeling depressed between 15 and 30 times a month; 16.1 percent reported feeling an inability to be close to someone they care about between 15 and 30 times a month; 10.3 percent reported feeling numb or nothing inside between 15 and 30 times a month.

These are just a few examples of the problems that a "significant" minority of women veterans are experiencing and might be applicable to the larger sample of women veterans.

Third, there were positive, growthful aspects associated with the Vietnam experience for many of the women in this sample.—Judging from the responses to the open-ended questions, both personal and professional gains were made that need to be more fully explored and understood. This positive aspect is a rarely examined aspect of both women and men veterans' experiences whose influence would be interesting to explore to determine if the awareness or recognition of growthful aspects of the Vietnam experience has any mediating effects on current adjustment. In addition, attention to this side of the veterans' experience may provide an additional source of pride to the veteran which might allow them and others to accept and view their experience more fully.

Fourth and finally, this sample has indicated that at least as far as biographical and demographic factors are concerned, women Vietnam veterans in this sample were different than men Vietnam veterans in other large scale studies.—This is true for such factors as age in Vietnam, racial background, education level, income level, and for symptoms of substance abuse and survivor guilt which have been identified by the research on men as important mediating and/or predicting variables but have not stood out in this research as significant predictors of PTSD's symptoms. These variables need to be more closely examined to determine their role in the women veterans experience.

IMPLICATIONS

I strongly feel my investigation will provide necessary and useful information for the clinician who works with female veterans in either counseling or research efforts. It also can help to guide legislators in understanding how to better address the needs and issues of women veterans. Mental health professionals and legislators alike would do well to be aware of the women veterans' strongly felt cynicism toward governmental agencies that this research revealed (approximately 65 percent of the women expressed this feeling), and to be prepared for the possible distrust, distancing, or anger that might occur. They should also keep in mind that for the 48.3 percent of the women in this sample who have sought professional mental health help since returning from Vietnam, less than one-half have ever discussed Vietnam with their counselor.

The counseling, research, and programatic implications are important for several reasons. Mental health distress among this sample was evident for a small, but what this investigator believes, is a significant minority. Combined with the observation that for those women who reported stress symptoms, approximately 70 percent of the symptoms were reported as still present today, the majority of which began first between homecoming and one year, we see a small group of women who have been in distress for long time. The 97 percent return rate and the fact that many of th women took the time to include additional handwritten pages to a 12 page questionnaire also seems to serves as an indicator that women veterans in our sample want and need to discuss their experiences. It is difficult to ignore this type of cry for help and understanding. Future research that focuses on women veterans could offer some preventative mental health interventions that might be taken so that we are not facing future women veterans who, 10 years after their war-time experience, are still in distress. This is particularly vital with the predicted increase of women veterans in the military in the years to come, and is a problem that should be addressed now in a preventative fashion before future problems arise.

Finally, then, this reserch serves as an indicator which cautions all of us not to treat or view female Vietnam veterans exactly like male veterans when conducting research, counseling, or in public policy. It substantiates the original conception that women veterans may be suffering mental health probelms which appear to be related to their Vietnam experience. Until more is known about women Vietnam veterans, their experience, and their reactions to them, we as researchers, clinicians, and legislators have a responsibility not only to explores their lives, experiences, and to initiate public policy, but to keep an open, investigative mind while doing so.

Thank you for your time and attention.

STATEMENT BY RUTH L. YOUNG, ASSISTANT STATE DIRECTOR FOR VETERANS EMPLOYMENT-NEW YORK, U.S. DEPARTMENT OF LABOR, VETERANS EMPLOYMENT SERVICE AND COMMISSION MEMBER, NEW YORK STATE, TEMPORARY COMMISSION ON DIOXIN EXPOSURE

Mr. Chairman and members of the subcommittee; my name is Ruth L. Young, Assistant State Director for Veterans Employment-New York, United States Department of Labor, Veterans Employment Service and Commission Member, New York State, Temporary Commission on Dioxin Exposure. I am proud to say, that on March 24, 1983, I will have completed nineteen years of honorable service with the United States Government, nine of which have been with the Department of Labor. I have been a member of the New York State Dioxin Commission, without compensation, since November 1980.

As the representative of a Federal and State organization devoted to the welfare and interests of veterans, including those who are female, and an honorably discharged veteran of the Vietnam era with service in France and Germany, I am indeed pleased to have this opportunity to appear before the Subcommittee on Hospitals and Health Care to present my views in support of the establishment in the Veterans' Administration of an Advisory Committee on Women Veterans.

As you are doubtless aware, the need for such a committee evolved from the perception of many female veterans, including myself, and other concerned individuals, both male and female, that a void exists in services, particularly in adequate and appropriate medical services, for the female veteran population within the VA Medical Care system today. In that connection, concerned veteran organizations have been involved in an exchange with female veterans, and the VA on this matter for sometime and feel very strongly that VA Hospitals need once again to become more aware of the needs of women veterans when disabilities make hospitalization necessary.

In an effort to further enlighten you regarding the concerns, I would like to share with you my own personal and professional experiences with the VA Hospital Care system and other women veterans.

Approximately 1969, I was hospitalized for one week at the VA Hospital, 23rd Street and First Avenue, Manhattan, New York. At this time my ailment was diagnosed as severe tonsillitis, and a tonsillectomy was performed shorly thereafter. I found myself, however, the only female on the floor of this huge facility, and thus limited to my room during the duration of my stay. My only consolation (because of my novel situation), was the visits of male veterans, many with tubes running from their bodies, who were also patients on this floor. In fact, it was at their encouragement that I drank the liquids that helped to ease the pain in my throat and to lower my fever. I have never forgotten the love and care extended to me by my male comrades, and the care provided by the Doctors and hospital staff at this facility.

On the other side of the spectrum, approximately 1979, while working in the field in Brooklyn, New York, I became ill and passed out in my car. In addition, I was experiencing pains in my abdomen, and heaviness in my legs. On this same day, I visited the VA Hospital, Fort Hamilton, Brooklyn, New York. I was diagnosed by the Doctor as being pregnant and referred to the Nurses' station for blood tests. I was later informed by the Nurse in charge, I would not receive the blood work-up, since the Hospital did not provide obstetric and gynecological services. In spite of my pleas that I was not pregnant, I was sent home untreated.

Thereafter, I went to the VA Hospital, Northport, New York, and was examined by a Doctor here. At this time, I do not remember the diagnosis. Eventually, I was mailed an appointment letter to see the visiting gynecologist, four months later. Subsequent telephone call to this facility disclosed that this was the earliest appointment available. Consequently, I secured a private gynecologist and in October of 1981, I experienced a partial hysterectomy for enlarged fibroid tumors and repair of umbilical hernia. Apparently the Doctor at the VA Hospital, Fort Hamilton, Brooklyn, New York had incorrectly diagnosed my tumor and hernia as a pregnancy.

While I hold no malice in my heart for what I consider to be a lack of sensitivity and callous treatment in the medical problems of females that I experienced at the two VA Hospital facilities, I would hope that this testimony would help to prevent future situations of this nature from happening to other female veterans who request care and medical treatment, especially emergency medical services, at VA Medical facilities.

In the capacity of Federal Veterans Employment Representative, responsible for the counties of Nassau and Suffolk in New York State, I have only had one occasion, in 1980, when a female veteran contacted me for supportive assistance because of medical problems which prevented her from working and earning income to financially sustain herself. She advised me she was a service connected disabled veteran of World War II and had been hospitalized at the VA Hospital, Northport, New York. She had been terminated by her former employer because of excessive sick leave and because of the extent of her medical problems, the Doctor would not release her to return to work. She was ineligible for unemployment insurance compensation and Social Security benefits. On her behalf, I was also contacted by the Chairman of Veterans Affairs, Suffolk County Legislature. In order to insure that she received the appropriate attention and services, I referred her case to the Coordinator, Forgotten Warrior Project, Disabled American Veterans, Levittown, New York.

In the capacity of Commission Member, State of New York, Temporary Commission on Dioxin Exposure, we have not had one female veteran who served in the Vietnam during the Vietnam era, who resides in New York State, contact this Commission.

In summation, this testimony should not reflect negatively upon all VA Medical facilities, and the staf that do provide and insure appropriate and adequate medical care and support services to their veteran population, including female veterans. I do feel however that establishment in the Veterans' Administration of an Advisory Committee on Women Veterans will insure that regulations and standards promulgated by the President, Congress and VA Administrator, will be alive and consistent at all VA Medical facilities, and provide female veterans the good feelings of sisterhood as a result of their service to their government and their country.

Thank you, Mr. Chairman and members of the subcommittee. I will be happy to respond to any questions you may have.

Statement of Norma J. Griffiths-Loris, Jr., Vice Commander, V.F.W. No. 28, Vietnam Veterans Assistance Post

This testimony begins with two chronological records. The first is of my experience in the military. The second is a record of my medical treatment since my medical retirement from the military. Both contain notes of pertinent information. They represent three periods of time and contrasting mental capabilities in my life.

Any receiver in the mental health care system certainly, and perhaps rightfully, has criticism of its delivery of that care. To be improperly diagnosed and then treated for ten years for that diagnosis is a source of anger for me today. Definition of a problem is a necessary step in treating any psychological disability. The practice of accepting a narrow range of symptoms as the normal or common ways of women to cope, puts off the attempt to define the problem. Even further, not to be considered for the diagnosis of Post Traumatic Stress Disorder, P.T.S.D., on the basis of erroneous assumptions about my experience in Vietnam, is devasting! My specific situation in dealing with these problems is described later in this testimony. Only two women have been admitted to an in-patient treatment program for P.T.S.D., the second only recently. Though I was a patient in a V.A. Hospital in June 1982, I was never evaluated for the program. In fact, I had to remind my doctor at almost every session that I had served in Vietnam. P.T.S.D. was listed as a primary diagnosis on the summary sent along from my V.A. outpatient therapist.

I don't know that I was ever really ashamed of what *I* did in Vietnam. I remember being proud of my ARCOM, Army Commendation Medal, but I also remember hiding it. I was never able to separate my anger and hatred about the war from my feeings about my experience and myself. My feelings about our country's involvement in Vietnam and its direction were set before I even left country. They were even more explicitly "explained" to me on my return. Being a female, it was easy for me to allow people to assume that I had not been there, to listen to their opinion, and to consciously avoid Vietnam completely. Unfortunately that also meant avoiding working on making that separation of my self-image and its incorporation into my hatred and anger. On rare occasion, when I did come out of the "closet", assumptions were made about my experience that I did not care to explain or refute. I avoided all contact with Vietnam, both emotional and physical. Contact with any reminders, either personal or professional, tapped that anger. I could not connect the two consciously. Later in my therapy, in 1975, even I started spouting learned phrases and ideas. The phrases "It was five years ago.", "It was busy." and "It's over." were my standard and only comments on my experience in Vietnam. I was professionally and personally disabled.

My professional disability took two major forms. First, I was unable to stand the sights and smells that associated me with that experience. The smell of burned flesh and the presence of a patient with a traumatic head wound were classics that bought on a robot like performance in or an avoidance of the situation. Second, despite my performance, I could never regain that atmosphere of professional respect experienced in Vietnam. I was taught and supervised there by peers, nursing peers, whom I respected. People cleared out of R&E, Receiving and Evacuation or Casualty Receiving, when casualties arrived, knowing they could only hinder our co-ordinated operation. New nursing arrivals in-country had to prove themselves first professionally. If they could not, they truly ended up socially unacceptable. Their work was supervised closely. Unnecessary death, due to stupidity, was a horror that was unforgivable. Every day brought so much death that we couldn't prevent, that we fought to prevent any other death. In contrast, in a later job, I was instructed by a medical student. In one example, I offered to start an intravenous after a student's numerous attempts. I was told that I probably couldn't do much better, only being a nurse, and was not given the opportunity. My anger began to seethe and my withdrawal and difficulty dealing with supervisors began. Those supervisors never even knew of this difficulty. The opportunity of anger on the job was not available. I often simply left.

My inability to define my own image and my passive acceptance of the erroneous evaluations by others, often professionals, drove me to escape. My route was perscription drugs and, when "things got bad", suicide. Here the lack of any support system affected me drastically. I was unable to cope, and as far as I was unable to determine, I was the only one unable to do so. I could no longer care, enjoy, or work, and I very much feared loosing control of an anger for which I could not locate a source.

As literature began to appear, it only seemed to address the male "combat" veteran. In 1981, I began to read the literature on P.T.S.D. and noticed striking similarities to my situation and feelings. It seemed the only differences were not in the problems, but in the ways of dealing with them. Those readings bought expectations of understanding from "fellow vets". That was not my initial experience. I stirred up feelings in those men that they, too, had been trying to forget. The enlisted men had limited contact with nurses. It was usually associated with being wounded, or ill, and flat on a canvas litter. It may have been their own experience, or that of watching a buddy. As nurses, we stayed in a more permanent area, had a living area and were believed to have many more comforts. We routinely treated prisoners and were somehow not even perceived as hating, or being able to kill. I repeatedly heard, "Well, you were in a hospital, weren't you?" and "You were in the rear." Suddenly, there was a "rear area" in Vietnam.

In late, 1981, when I began to think about my feelings about Vietnam, my standard test question was, "Did you read about people spitting on Vietnam veterans in the airport?" The response I received was, "Were you spit on?". I still do not remember my return to this country. Again, I perceived myself as "jumping on someone's bandwagon" and chasing a cure for a depression defined for me as chronic—something that I would just have to adjust to. I was told, "With the help of medication, you can lead a 'normal' life." Actually, I had been on almost every psychotropic medication and still could not enjoy, share, love, and sometimes work.

Late 1981 my divorce was final and my husband finally had left the house and signed the mortgage and deed over to me. I was still able to make it to work usually. Things should be improving but I found my depression deepening again. I experienced physical problems—epigastric pain and an irregular heartbeat—that prompted the doctor to suggest a weight loss program. I was then 205 pounds! I applied for Vocational Rehabilitation. My psychiatrist's letter did not support my being disabled in nursing. It did not establish any connection between my job and my symptoms. Financially, I was not able to quit my job. Bills from my marriage and hospitalizations loomed far into the future.

As I had a 30 percent service connected disability, I could be treated at the outpatient clinic for my disability. I went through the intake interview a chronically depressed, socially isolated diagnosed schizophrenic. That diagnosis officially still persists today, but through the efforts of my therapist and myself, P.T.S.D. appears on my outpatient file. The next step is documentation and rating. That is a battle which I can not undertake right now. Dealing with the daily stresses of school, pregnancy, and separation of resolvable and unresolvable anger, both past and present, are my priorities now. I finally realize that without knowledge, without support, and with learned passivity, I reacted poorly to the overwhelming stress of Vietnam. With help, I will never react that way again.

I am now officially disabled in nursing. I am attending Temple University under a program of Vocational Rehabilitation and am pursuing a Bachelor of Arts Degree, majoring now in Honors. In my junior year I will switch my major to Psychology. The education and documentation involved took much time. Reading Title 38 and interpreting it in relation to a psychological disability and not a physical one is neglected by the Veterans' Administration. Because I am starting so late, even though I have not used any of my G.I. Bill benefits, I must finish my program by December 1985. That means, starting last January, I must also attend all summer sessions for the next three years. Extensions for the program can be obtained but, again, relating the existing regulations to a psychological disability will take documentation, medical statements that are difficult to obtain, and time. Defining eligibility for programs to which I have a "right" is the reality of being a Vietnam veteran, especially a female Vietnam vet.

OBTAINING MEDICAL CARE NOT RELATED DIRECTLY TO MY SERVICE CONNECTED DISABILITY

Obtaining health care not directly related to the service connected disability is difficult for any veteran, but especially for the woman vet. The health care she requires is not usually ever available on a routine basis and restrictions to admission to a hospital can be affected by the availability of a room she can occupy.

In August 1982, I entered a relationship for the first time in years. By the end of September, it had progressed to a sexual relationship. My irregular menstrual cycle made over-the-counter birth control risky at best. During an Agent Orange physical, I found that there was a GYN, gynecological, clinic at the V.A. OPC. When I returned to make an appointment, I was told that there was no clinic. After hearing this story a number of times, I one day located the nurse who had supervised my exam. She referred me to an office on the fifth floor where someone would make me an appointment. That woman was not in her office and her co-workers denied that any clinic appointments were made there. After another trip to the nurse, and appointment was made for November. The doctor did not have the necessary equipment to fit a device and wanted to see me in his office. When I consulted the benefits counselor for a voucher for the office visit, she informed me that I would have to have a service connected disability of 50 percent, or above, to obtain any other care besides my disability. Though unemployed, I could only be treated for schizophrenia! My therapist had to submit a consult relating my need for such treatment to my disability. The consult was submitted in December. I was notified of its approval in early January. My menstrual cycle was then 15 days late. My private doctor reported my pregnancy test as positive the next day. At the end of January, I received a voucher for an office visit on February 4th for the minimal charge for fitting of a birth control device. My husband and I are happy, but hoped to pospone this decision until many problems—educational, physical, and psychological—could be worked upon.

OBTAINING AN I.D. CARD UNDER MY MARRIED NAME

The V.A. does not, under any circumstances, provide medical care for normal pregnancy and delivery. As a retired vet with a 30 percent service connected disability, I am eligible for Champus for 75 percent of that care. To have Champus pay these bills, I must obtain a statement of non-availability from the local military medical facilities certifying that this care is not available. To obtain this form in my married name—the name on my medical records—my I.D. card must also be in my married name.Though I obtained such a card when married the first time, I was informed this time that I would have to change all my records first. I.D. cards could only be issued in the name on my discharge papers. I confirmed this information at the Retired Personnel Center in Indiana and at the I.D. card issue facility at Fort Dix but the personnel at Fort Dix were able to make some phone calls and eventually issue me an I.D. card in my married name. Even at Indianapolis, I was unable to find the reason for this ruling. How could it affect anyone except those who do legally change their name, most commonly women who marry. I can see reason for notification and official recognition of name change. Can this be done by providing a certified copy of the legal proof of name change and filling out the appropriate paperwork when the card is issued?

I have addressed some of the frustrating aspects that I have experienced that could be changed—some by simply obtaining the correct information, some that will take changing the established rules, some that require looking at interpretation of rules in a psychological and not physical basis. Misinformation is rampant—especially that information regarding elegibility for benefits. The presence of HR 1137, establishing an Advisory Committee on Women Veterans in the Veterans' Administration, is very encourging. Dealing with changing Administrations in the V.A. has desenchanted me with the temporary establishment of such a committee. I believe that it is essential to the proper working of the committee for it to be established on a permanent basis. A task which only Congress can accomplish. I come to the Subcommittee with a letter from the VFW Post, which I serve as Jr. Vice Commander, for reccomendation of rapid approval of H.R. 1137. The Post is the Vietnam Veterans Assistance Post, VFW Post #28 of Philadelphia, Pennsylvania.

Thank you.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION AND JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, the American Legion appreciates this opportunity to express to the Subcommittee our views on the status of and future need for medical care provided for women veterans by the Veterans' Administration; on H.R. 1137, a bill calling for the establishment of an Advisory Committee on Women Veterans within the Veterans' Administration; and on the GAO report under date of September 24, 1982 entitled "Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits."

However, with your permission Mr. Chairman, before addressing these issues, may we take this opportunity to express the gratitude of The American Legion to those women who, throughout the colorful yet turbulent history of the United States, have served in the Armed Forces of this nation. The American Legion is proud of the fact that female veterans have been welcomed in our membership since the founding of this organization in 1919. As early as the 1930's a woman served on the Legion's National Executive Committee, one of our two policy making bodies. Over the years a substantial number of ladies have been elected to the respected position of State Commander, and other National, State and local offices. Women veterans have provided valuable service as professional employees of The American Legion since before the end of World War II, and at the present time we are privileged to have females serving the Legion as Claims Representatives, Department Service Officers and Accredited Representatives in State and County veterans service offices.

There are currently over 100 American Legion Posts totally membered by female veterans and thousands of women members in other Posts throughout the United States.

May it be said that The American Legion is extremely honored at this time to have serving as a National Vice Commander, Mrs. Margaret M. Malone of Trenton, New Jersey.

Over the past two decades the number of women serving in the Armed Forces has increased phenomenally, thus the number of females in the veteran population is growing accordingly. This lends additional importance to the fact that emphasis needs to be placed on ensuring that the medical needs of female veterans may be cared for in every medical center and outpatient clinic under the jurisdiction of VA's Department of Medicine and Surgery.

It is obvious that women have some unique medical needs which must be addressed. It is the belief of The American Legion that every VA medical care facility should have the capability of conducting pelvic examinations, to include pap smears and other tests, and breast examinations in the course of providing total physical examinations to determine the status of the female veterans' health. Likewise, we feel it imperative that inpatient and outpatient gynecologic services be readily available for both service-connected and nonservice-connected conditions. Beyond the gender related conditions, the physical problems of female veterans should not vary greatly from those experienced by their male counterparts.

H.R. 1137—Would amend title 38, United States Code, to establish an Advisory Committee on Women Veterans, the members of which would include women veteran representatives; individuals who are recognized authorities in fields pertinent to the needs of women veterans, including health care needs; male and female veterans with service-connected disabilities; the Secretary of Labor, or a designee thereof, assigned after consultation with the Assistant Secretary of Labor for Veterans Employment; the Secretary of Defense, or a designee thereof assigned after consultation with the Defense Advisory Committee on Women in the Services; and the Chief Medical Director and the Chief Benefits Director or their designees. The purpose of the Committee would be to regularly advise the Administrator on the administration of VA benefits for women veterans, and the unique needs of women veterans with respect to compensation, health care, and rehabilitation.

The measure further provides that the Committee shall submit a report to the Administrator not later than July 1, 1984, and not later than July 1 biennially thereafter, on the programs and activities of the Veterans' Administration insofar as they pertain to women veterans; including an assessment of their needs with respect to compensation, health care, and rehabilitation. The report would also include a review of the VA's activities designed to meet such needs, and the Committee's recommendations, including those calling for administrative and legislative actions, which the Committee consider to be appropriate. If enacted, the effective date of this Act would be October 1, 1983.

The American Legion is supportive of the establishment of an Advisory Committee on Women Veterans within the Veterans' Administration. Our experience with Congressionally mandated advisory panels, the Geriatrics and Gerontology Advisory Committee and the Advisory Committee on Former Prisoners of War, established within VA, has been most favorable. Both of these committees' members are to be commended for their perseverance, hard work and intense deliberation toward the important issues under their respective jurisdictions. We realize the value of the input of such advisory groups to both their veteran constituencies and the VA. And the Legion firmly believes that an Advisory Committee on Women Veterans would provide equally important data on which to determine the needs of female veterans, and whether or not these needs are being totally addressed by the Veterans' Administration.

Mr. Chairman, we now shall briefly comment on the General Accounting Office report entitled "Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits."

In conducting the study, GAO's objectives were to determine whether VA was equipped to provide medical care to female veterans; effectively planning for the anticipated increase in their demand for medical services; adequately informing them of the benefits available; and addresing their psychological problems through its Readjustment Counseling Program for Vietnam era veterans.

The report states that GAO representatives visited 7 medical centers, 1 psychiatric hospital and 5 vet centers. They additionally contacted 23 medical centers and independent outpatient clinics, 5 psychiatric hosptials, and 4 domiciliaries. In addition, GAO interviewed VA Central Office officials and representatives of veterans organizations.

Due to the length and complexity of the report, we shall limit our comments to the conclusions contained therein, the GAO recommendations to the Administrator of Veterans Affairs, and VA's comments on these recommendations.

The report concludes that because of the high proportion of male veterans, the VA health care system has traditionally been oriented toward male needs. Although the primary mission of the VA health care system (according to GAO) is to meet the needs of service-connected veterans, VA facilities have generally been sized and staffed to accomodate both service-connected and nonservice-connected veterans. Thus, male veterans can generally obtain needed care from a VA facility regardless of service connection. It was concluded that the same is not true for female veterans because of problems in insuring privacy in older facilities and variations in the availability of gynecological care. GAO reports that it has, in the past, questioned whether VA should size its hospitals to accomodate nonservice-connected veterans. However, the report states that as long as VA continues to do so, it should insure that male and female veterans have equal access to facilities and treatment programs.

GAO further concluded that VA needs to increase its staff's awareness of female veterans' unique medical needs and do more to address those needs. It was stated that this is becoming more important because of the increasing numbers of female veterans and the increasing proportion of them who are expecterd to have service-connected disabilities. GAO reported that without a concerted effort by VA to identify and address female veterans' needs, neither short-term renovation projects nor long-term facility planning will substantially increase their access to VA medical care.

The report is dated September 24, 1982.

The first recommendation proffered by GAO is that the Veterans Administration improve female veterans' access to outpatient gynecological care and other care not available at VA facilities by negotiating sharing agreements with DOD or other Federal hospitals; contracting with private gynecologists; or developing in-house capability.

The Veterans Administration replied that it will develop guidelines to help all VA health care facilities improve female veterans' access to outpatient gynecological care and other care not available to them at VA facilities.

The American Legion has been provided Department of Medicine and Surgery Circular 10-83-14, dated January 28, 1983. The circular provides directives with which all VA medical care facilities are to comply with regard to providing specialized care to female veterans; identifying and correcting physical barriers that limit access of female veterans to any program; and developing a written plan for the care of female veterans by June 1, 1983, for submission to VA Central Office. The Legion's Field Representatives have been instructed to view the manner and timeliness in which the facilities are progressing with the necessary improvements during regularly scheduled site visits to medical centers and outpatient clinics.

The GAO report recommended that VA revises privacy standards and insure that future construction or renovation projects correct privacy limitations that limit women's access to VA facilities and treatment.

In reply, the Veterans Administration said that, as guidelines and instructions for interim construction are revised, sensitivity to the special facility needs of female veterans will be highlighted and encouraged. According to VA, a forum will be developed through medical center engineering officer conferences and conference telephone calls to share successful local solutions to female patient care and privacy problems. VA said that health care facility construction will provide the special facilities needed to treat female veterans when VA's health care programs require these facilities. However, VA said that because of existing physical constraints and limited resources, interim solutions are often necessary even though they require a compromise in program scope and staff convenience.

GAO recommended that the Administrator instruct VA medical facilities to identify all treatment programs that cannot accept female patients and develop alternative ways to provide the care such as sharing agreements or increased use of the inpatient feebasis program.

DM&S Circular 10-83-14, dated January 28, 1983, provides that each medical center and outpatient clinic will review their current method of providing outpatient gynecologic services for female veterans and upgrade those needing improvement by June 1, 1983. As previously mentioned, the Circular also provides that each facility must prepare a written report by June 1, to be submitted to VA Central Office. Among the issues to the addressed in the plan is the provision of inpatient gynecologic services for hospitalized female veterans as well as those in Va nursing homes and domiciliaries.

The American legion will be closely watching the development and implementation of these improvements.

It was recommended by GAO that VA develop projections on the numbers of service-connected and nonservice-connected female veterans expected to seek care from VA and use such data in planning future construction and renovation projects.

The Veterans Administration replied that it will prepare estimates which reflect the age, county of residence, and other statistics regarding the female veteran population. According to VA, the estimates will be used in conjunction with current age-specific utilization data to project future use.

It was recommended that the administrator, through the Chief Benefits Director, evaluate female veterans' awareness of benefits.

The Veterans Administration stated that this recommendation could be quickly implemented but questioned the need for or value of such information, because female veterans are, first and foremost, veterans and as such, have full access to the full range of benefits information and assistance provided to all veterans. VA said that the assistance available to all veterans includes tollfree telephone service in all 50 States and access to any regional office for a personal interview.

GAO recommends that VA establish procedures to insure that female veterans will be notified of major changes in benefits that affect them, and that outreach efforts be expanded to include veterans organizations with predominately female memberships.

The Veterans Administration does not see a need to subdivide veterans by sex because the same benefits are available to all veterans; and training at military separation points, breifings, and benefits orientations are all designed to disseminate comprehensive information regarding VA benefits and services. VA stated that establishing separate procedures for female veterans is unnecessary and duplicattive of ongoing procedures. The VA did agree with expanding outreach efforts to predominately female veterans organizations and said that action will be taken to do so.

With respect to the recommendations that VA evaluate female veterans' awareness of benefits, and that procedures be established to insure that female veterans will be notified of major changes in benefits that affect them, The American Legion must take exception with the replies furnished by the Veterans Administration. Unfortunately, many women veterans, especially those who served during the Vietnam era, are not as apt to join veterans organizations as are their male counterparts. Further, it has been found that many former servicewomen do not even consider themselves as veterans Therefore, in many cases there exists a void of awareness as far as eligibility for VA benefits and programs by some female veterans is concerned. The Legion feels that an effort should be made by the Veterans Administration to ensure that all female veterans are aware of their rightful eligibility.

Mr. Chairman, we are encouraged by recent steps taken by the Department of Medicine and surgery aimed toward improving the provision of specialized medical care to female veterans; the first being the appointment of Dr. Susan Mather to develop and supervise the changes necessary for the accomplishment of such improvements within the VA medical care system. Dr. Mather has assured us that the staff of each medical facility is being sensitized with respect to the treatment of women. DM&S Circular 10-83-14 provides the basic directives to all VA medical facilities necessary for the provision of equitable care for female veterans.

The American Legion feels that these and other actions that are being initiated will lead toward a more positive awareness of female veterans' needs in all VA health care programs. And the Legion will be monitoring this program to ensure that male and female veterans ultimately will have equal access to VA medical care.

Mr. Chairman, that concludes our statement.

STATEMENT OF PETER B. CURRIER, AMVETS DEPUTY NATIONAL SERVICE AND LEGISLATIVE DIRECTOR

Mr. Chairman, AMVETS thanks you for the opportunity to appear before you and offer our views on the current status and projected need for inpatient and outpatient services for women veterans through the Veterans Administration's Department of Medicine and Surgery.

Recently AMVETS canvased its National Service Officers to determine any deficiencies in medical care for female veterans and without exception we were advised that the medical needs of the female veteran were being adequately met by the Veterans Administration based on its current indicated needs. The majority of those canvased also stated gynecological care was adequately provided on a contract basis at present.

Traditionally, the Veterans Administration has been utilized by male veterans and we understand this since the greater part of the veterans' population is made up of men. Traditionally, the female veteran has not utilized the Veterans Administration medical facilities since for many reasons they have chosen to utilize private physicians or have, because of the overwhelming male veterans' population shied away from petitioning services of the Veterans Administration. We feel this is due in no small part to a lack of public relations on the part of the Veterans Administration in the past and also would opine that if the Veterans Administration were to engage in a public relations effort to encourage the female veteran to come forward that this situation would change. Many female veterans do not know of the fine medical care provided at Veterans Administration hospitals nationally and, indeed, do not know of the capabilities of the agency. If however, they were encouraged to come forward and to utilize the facilities they would realize that they are entitled to free care of the highest quality.

Other difficulties which prevent female veterans from utilizing to the full extent the facilities available to them is the fact that the Veterans Administration because of past experience has geared itself to the primary care of male veterans. In so doing the Veterans Administration has failed to provide for adequate privacy of its female constituency and we understand that the Department of Medicine and Surgery is undergoing a self examination procedure in an effort to determine its inadequacies in this area and to make provisions for improvement. With this undertaking we are extremely pleased. In this self-examination procedure however, we would hope that the Veterans Administration will seriously consider the usage in its outpatient facilities of a gynecologist. Because of the low usage of V.A. Medical Centers by female veterans at present, we would suggest that this be done on an as needed basis, however, in the event that increased needs are indicated we would also hope that the Veterans Administration would engage in a weekly scheduling of a gynecologist.

Dr. Custis and his staff has kept AMVETS and the other veterans' organizations informed as to the status of its reaction to the General Accounting Office report of September 24, 1982, in an effort to determine present and future needs of the female veteran. We feel that the Veterans Administration is moving forward in this area and would commend Dr. Custis and his staff for its prompt response to the report.

Regarding H.R. 1137, Mr. Chairman, we would commend you for the introduction of this Bill to establish an advisory committee on women veterans. Although we feel that basically that such an advisory committee on women veterans would closely parallel present studies underway within the Veterans Administration, it will to a degree insure the recognition of the unique problems which are faced by the female veteran and, as such will act to a degree as an oversite committee.

In assessing the problem of providing proper care for the female veteran AMVETS is of the opinion that basically the Veterans Administration because of lack of application by the female veteran for care is not in this instance at fault. We would hope that a certain effort be undertaken either by the advisory committee, if established, or by the Veterans Administration to educate the female veterans of America of the services readily available through the Veterans Administration.

Again, Mr. Chairman, we thank you for this opportunity to appear before you today to offer our views on this subject matter.

STATEMENT OF JOHN F. HEILMAN, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Subcommittee, on behalf of the 745,000 members of the Disabled American Veterans, may I say that we deeply appreciate the opportunity to participate in today's hearing which deals with the subject of the health care needs of American's female veteran population and how these needs are presently being met by the Veterans Administration.

In your letter of invitation to testify, Mr. Chairman, you requested our views on (1) H.R. 1137, a bill that would establish in the Veterans Administration an Advisory Committee on Women Veterans and (2) a 1982 Report published by the General Accounting Office entitled, "Actions Needed to Insure that Female Veterans Have Equal Access to VA Benefits."

Before proceeding, Mr. Chairman, I wish to state that the Disabled American Veterans has never viewed our nation's veteran population with "gender-based" distinctions, policies or sentiments of any kind. From its inception in 1922 and continuing to the present, the DAV has welcomed to its rank all honorably discharged service-connected disabled veterans of wartime service, male and female alike. Women DAV members have in the past held and presently do hold elected offices in our organization. Currently, women veterans serve as the Commanders of the DAV in three states—Utah, Florida and Hawaii. In addition, our nationwide corps of professionally trained fulltime employed National Service Officers includes three service-connected disable female veterans, two of who are of the Vietnam Era.

Mr. Chairman, as far as the DAV is concerned, we welcome and encourage the active involvement of former female members of our Uniformed Services, both in our own orgnization and the veterans' community at large.

H.R. 1137

This measure was introduced in the House of Representatives on Feburary 1, 1983. Cosponsored by yourself, Mr. Chairman, and Mr. Edwards of California, it would amend Chapter 3 of Title 38, U.S. Code, statutorily requiring the Administrator of Veterans Affairs to establish an Advisory Committee on Women Veterans.

Under the terms of the bill's provisions. membership of the Advisory Committee shall consist of:

1. Members appointed by the Administrator from the general public, including: (a) Representatives of women veterans, (b) Individuals who are recongnized authorities in fields pertient to the needs of wome veterans, and (c) Representatives of both male and female veterans with service-connected disabilities.
2. The Secretary of Labor or his designee,
3. The Secretary of Defense or his designee, and
4. The Chief Medical Director and Chief Benefits Director of the VA or their designees.

The bill further requires the Administrator to consult with and seek the advice of the Committee on matters affecting the needs of women veterans with respect to the VA programs of compensation, health care and rehabilitation.

The Committee is required, no later than July 1 of 1984 and no later than July 1 of each second year thereafter, to submit to the Administrator a report on the programs and activities of the VA insofar as these programs and activities pertain to women veterans. This report, in turn, shall be submitted to the Congress along with any comments and recommendations of the Administrator (in addition to these statutorily required reports, the Committee may submit to the Administrator other reports and recommendations it considers appropriate.)

Finally, the Advisory Committee on Women Veterans shall remain in existence until terminated by law.

Mr. Chairman, I wish to make three specific comments on the bill that I hope you and the members of the Subcommittee will consider in your recommendations to the full Committee.

First, we believe the Chairman of the Advisory Committee should be a woman. We are not requesting that this be placed in the bill as a statutory requirement (feeling that it would be unwise from a precedential standpoint to do so), but we think it entirely appropriate for the report language that accompanies the bill to indicate that it is the strong desire and intent of the Congress that the Committee be headed by a women.

Seondly, and again referring to the Committee membership, it is our belief that those members who are "recognized authorities in fields pertient to the needs of women veterans" should be, whenever possible, women (who are, of course, otherwise qualified). We feel this is important and necessary, especially with regard to authorities in the field of gynecology. Again, we recommend that such a statement of intent be placed in the bill's report language.

Finally, we believe that the Committee should be statutorily required to meet a minimum number of times per year. We recommend at least two times per year.

Having stated this, Mr. Chairman, I urge that the bill be favorably acted upon by the Subcommittee.

GAO REPORT—ACTIONS NEEDED TO INSURE THAT FEMALE VETERANS HAVE EQUAL ACCESS TO VA BENEFITS

As you are aware, Mr. Chairman, GAO submitted this report in September of 1982, after having visited or contacted 45 VA medical facilities and interviewing officials at VA Central Office, as well as representatives of several veterans' organizations.

Mr. Chairman, we have reviewed the report and, as it is a matter of record and shall appear in the official transcript of today's hearing, I shall not further duplicate the record by listing its various findings. I shall, in a moment, comment upon its recommendations.

For your information, I have attached to my testimony the written comments of a service-connected disabled female veteran of the Vietnam Era who is currently employed by the DAV as a National Service Officer. Her views on the health care needs of female veterans were solicited by this office upon being apprised of today's hearing. We feel that, as a disabled veteran and woman, and as a person who is professionally involved in counseling and representing veterans (both male and female) in obtaining VA benefits and services, she is a particularly qualified observer of female veteran health care needs.

You will note, after persuing her comments, that many of her views parallel those contained in the GAO Report—particularly those in the areas of:

1. Privacy—the communal nature of sleeping and bathing arrangements.
2. Physical examinations of female veterans—lack of pelvic and breast examinations and pap smears.
3. Deficiencies in the area of fee-basis care.
4. Attitudinal views of VA medical employees and male patient veterans.

Mr. Chairman, there is no doubt in our minds that female veterans—simply because of the fact that they are female—do not have access to VA health care as do their male counterparts.

The fact that is so is understandable. True, the system has never intentionally perceived veterans on the basis of their sexual gender. Eligibility to and delivery of benefits and services have always been concerned with such distinctions as: the honorable nature and length of military service, the peacetime or wartime nature of military service, and whether a wound, injury, disease or death was incurred during military service.

Yet, until recent years, the virtual absence of females in the military and consequent lack of female emergence in our nation's veteran population has, happily or unhappily, masked any sexual bias that has evolved in the system.

However, women are now serving in the military in ever increasing numbers. They are becoming a sizeable minority in our veteran population (according to 1980 census figures, of the 29 million plus living veterans, 1,108,000 are female). Without question, the needs of these female veterans must be met and, as indicated by GAO, the current failure to do so is located primarily in the area of VA health care.

Mr. Chairman, the DAV finds itself in basic agreement with the actions recommended in the GAO Report. Specifically, that efforts are necessary to insure that:

1. Men and women have equal access to VA treatment programs and medical facilities.
2. Women treated in VA facilities receive complete physical examinations.
3. Women treated in VA facilities receive needed gynecological care.
4. Sufficient plans are made for the anticipated increase in the female veteran population.
5. Female veterans are adequately informed on their benefit entitlement.

One final point:

It is obvious, Mr. Chairman, that in the short run, the VA may have to utilize fee basis care and/or reciprocal care arrangements with military medical facilities and affiliated medical schools in order to provide quality health care to female veterans—particularly in the area of outpatient care.

However, we believe that the ultimate, long-range goal of the VA must be to develop full inhouse capabilities for the comprehensive inpatient and outpatient health care needs of our female veteran population. In our opinion, such a course will, in the long run, prove to be cost effective. Also, not to do so would be to continue the gender-based discrimination that is now recognized to exist in our VA health care system.

Mr. Chairman, this concludes my testimony. I wish to again thank you and the members of the Subcommittee for extending me the invitation to participate in today's hearing.

Disabled American Veterans,
V.A. Regional Office,
St. Petersburg, Fla., February 22, 1983.

Mr. John F. Heilman,
National Legislative Director, Disabled American Veterans, National Service and Legislative Headquarters, Washington, D.C.

Dear Mr. Heilman: This is in response to your letter of February 8, 1983 requesting my views of VA health care services for women veterans.

As a woman veteran and as a National Service Officer for the Disabled American Veterans, I would like to thank you for the opportunity to express my opinions and suggestions on this subject.

However, prior to answering the questions, I feel it is important to mention that information currently available to me estimates over 800,000 female veterans nationwide with 36,500 in Florida alone. These numbers indicate the need for the Veterans Administration to establish a plan to provide medical care for those eligible women veterans.

Additionally, October 1982 Department of Defense statistics showed 189,515 women on active military duty and some experts believe this number will increase in the future. Due to the depressive state of our economy, more women may enter the military to take advantage of the training and educational opportunities offered to active duty personnel.

I believe that the Veterans Administration needs to take this into consideration, as these women will eventually become veterans and potentially eligible for Veterans Administration benefits, including medical care.

Also, because of these facts, I feel it is important that the Veterans Administration be aware of several problems that women veterans currently face seeking treatment from the VA Medical Care System. It is just as important, that when taking steps to correct these problems, careful planning and guidance be given to VA personnel in order to produce positive and worth while results.

I should point out before proceeding, that many of my complaints and suggestions could be appropriate answers to several of the questions you have asked, however, to avoid repetition, I will mention each problem only once.

1. What problems do you see that the VA Medical Centers and outpatient clinics have with respect to the delivery and availability of needed health care services by eligible women veterans?

Most problems that I have seen or heard are caused by the lack of understanding and acknowledgement of women veterans, their needs and their rights on the part of VA medical care personnel. In my opinion, this problem certainly affects the Veterans Administration's delivery and availability of medical care to many women veterans.

One complaint from women veterans, lies in their dissatisfaction with the attitude of some VA physicians. Some of these doctors have told female veterans that because they are both non-combat veterans and women, they are not deserving of Veterans Administration medical care, and perhaps they are not considered veterans at all. It is my opinion that this attitude is not deliberate or malicious, but due to a lack of familiarity by VA personnel of the women's role in the service and her needs as a veteran.

However, while this may not apear to be a major problem on the surface, it sometimes results in the lack of uniformity in the quality and delivery of medical care extended to the woman veteran as compared to that provided the male veteran.

Even with the increasing number of women veterans (admittedly the woman veteran is still in the minority) a woman seeking medical care at a VA facility is still not a common occurrence. Therefore, Veterans Administration personnel have not yet become acclimated to her presence or to her individual needs or rights. This problem frequently leads to frustration, anger and confusion for the woman veteran; and in many cases these women unhappy with differential medical treatment and indifferent attitudes by some VA physicians are driven to seek out other sources of medical care. Consequently, the woman veteran remains outside of the VA Medical Care System, even though she may be legally entitled to these services.

Another problem voiced by many women veterans is the lack of availability of treatment for gynecological problems. I feel there is a strong need for the VA to recognize the importance of in-house gynecology examinations/treatment and that this should be made available in VA Medical Centers that are properly equipped and staffed in this field.

To continue, I feel there are many other smaller problems, but these appear to be caused by the women veterans unfamiliarity with the entire VA System. This frequently causes severe communication problems betewen the VA and the woman veteran, causing further difficulties in the delivery and availability of medical care to them.

It is my opinion, that all of these problems can be corrected to ensure proper medical treatment for eligible women by educating VA personnel (particularly physicians) and inviting the woman veteran back into the VA Health Care System.

2. What problems do eilgible women veterans encounter when seeking needed health care services from the Veterans Administration?

One burdensome problem women veterans encounter is the general inability, or at least inconsistency, within the Veterans Administration to adapt its medical facilities to the individual needs of the eligible women veterans seeking needed medical care.

Frequently, women veterans admitted to VA Hospitals are issued mens garments, including slippers, robes and pajamas. Being forced to wear embarrassing and uncomfortable bedwear is certainly unnecessary and this can make an already unwanted hospital stay or severe illness far more difficult. This small but annoying practice is compounded by being admitted to an inappropriate or make-shift hospital ward, forced to use male bathrooms (often poorly converted for female use), or restriction from some recreational activities on hospital grounds because of special security practices for women veterans.

Surprisingly, on the other hand, some women veterans actually received preferential treatment in comparison to that given male veterans. This VIP treatment frequently occurs because of the lack of standard accommodations for women in VA Hospitals. An example of this would be placing the women veterans into private rooms only because there is no other place to put them. This unassuming problem can cause some male veterans and VA hospital staff to resent the special treatment given to these women.

Also, when a woman veteran is admitted to a VA hospital she is sent for a gynecological examination no matter what her major medical complaint is. Frequently, these examinations are performed by a non-specialist in that field. Because of the intimate nature and frequency of these examinations, I feel that a gynecology specialist should be on staff at VA facilities. Without a specialist conducting these examinations, this poses a question to me as to whether these women veterans are receiving proper and feasible medical treatment.

Perhaps the most serious problem women veterans encounter is caused by a small group of individual VA physicians. Some VA doctors have made physical sexual advances (some cases actually constitute an attack) toward female veterans. Unfortunately, many of these advances are not reported, apparently due to the fact some women feel they do not have open channels within the VA to offer their complaints. Also, it should be remembered that when these problems occur, the woman is most likely physically ill, rendering her unable to cope with the entire situation. Additionally, she may be afraid of any ramifications (real or not) against her by the VA physician, or she may be apprehensive about her VA claim, if this threat has been made clear to her by the VA physician involved.

It is also my opinion that there does not appear to be a mechanism within the Veterans Administration System to ensure that a female attendant be present during lengthy or intimate examinations. But, I must mention here, there are cases where a nurse has been present when unauthorized sexual advancement has been made by a VA physician toward a female veterans, but the nurse seemed impervious to it. It seems apparent from this, that there are also female VA personnel who are also hesitant to report these abusive actions.

Just as in the civilian community, these problems must be dealt with appropriately. If not, it could result in negative publicity, legal entanglements, involvement of families and can literally destroy lives as well as the image of the VA. Therefore, immediate steps must be taken to ensure the safety and well-being of the women veterans and that proper medical examinations are performed.

3. How would you view (as well as other women veterans) VA contract health care services (fee basis) for all eligible women veterans, including those who are non-service connected?

Since we are already aware that most VA facilities are not capable of offering total medical care to women veterans, I find it interestinfg to review Title 38, USC, Section 601 (C) (iv). This section describes the contracting of private medical facilities specifically for hospital care for women veterans. When Title 38, USC, Section 601 (C) was amended to include subsection (iv), the fact was apparently recognized by Congress that the VA did not have the capabilities to extend medical care to all women veterans. However, I do not feel that there is justification now, medically or financially, for farming out a large portion of eligible women veterans to contract facilities.

One reason is due to the increase in our cost of living as most private medical facilities and physicians (particularly certain specialistis, i.e. neurologists), will also increase the cost of their medical care rendered. Though I am aware that the VA pays for fee basis, I feel the increase in civilian medical care will escalate far above what the Veterans Administration would pay and above what the Veterans Administration could render these medical services for in-house.

At first glance, it may not appear that the VA could perform all medical care at a lower cost for the service connected women veterans (including those rated 50 percent or above). However, there are many other women who could benefit from making total care for women available through the Veterans Administration. Specifically, Title 38, USC, Section 610 (a) and Section 612 (f) (1) authorize treatment for non-service connected veterans while Title 38, USC, Section 613 authorizes treatment for some wives, widows and dependents of certain veterans.

Therefore, I feel that if those women eligible for care under these provisions of Title 38, USC are encouraged to come to the Veterans Administration for care; and if the VA is properly equipped and staffed to provide a full range of health care services to women veterans, the VA will realize a lower cost of care than that which the contract physician or facility could provide.

It also must be remembered, that in some cities, there are many doctors who are hesitant to accept fee basis cards, just as they are refusing to directly bill insurance companies. This would force women veterans to pay out of their own pocket in advance, possibly causing her financial hardship.

Finally, I am aware of VA Regulation 6060 regarding outpatient care for eligible persons. It is stressed that medical services may be furnished within the "limits of VA facilities" to those eligible veterans. It is my opinion, and that of many other women veterans, that medical care for women has been considered a limitation in this regard, and that the Veterans Administration should take steps to make total and proper medical care available to those women eligible by law.

4. What suggestions would you have with respect to VA health care services for those service connected disabled women veterans who are rated by the Veterans Administration 50 percent or more disabling and who are eligible for complete VA medical care for any condition? For example, should the VA provide this care in-house, contracted out or is there some other suggestion you might have?

I have already stated that I feel all eligible women veterans are entitled to proper and total medical care treatment in-house. However, I am particularly concerned with the women veteran rated at 50 percent or more. Title 38, USC, Section 612 (f) (2) authorizes medical care for any disability for a veteran rated 50 per centum or more. Since Title 38, USC, Section 612 makes no differentiation between male and female veterans, I feel it is the VA's obligation to ensure that women veterans receive the proper medical care authorized by law. And as I stated, I feel this can be done at VA facilities at a lower cost than at contract facilities.

Further, under the same Title 38 USC law, it states that these medical services are authorized as the Administrator finds to be reasonably necessary. Certainly, such care as gynecology would now be considered reasonably necessary under this law.

Quite frankly, I am sure VA medical personnel and facilities are indispensable and invaluable in terms of their contributions to veterans, however, this should include women veterans as well.

However, it is important to point out that even with these problems I have mentioned, there are many women veterans who continue to have positive encounters within the VA Medical Care System. I believe that once the major problems have been identified and corrected, the VA will then be able to deliver timely and quality medical care to all women veterans legally eligible for this treatment.

In order to begin making changes, the VA and Congress must look closely as to the reason the Veterans Administration was originally started and I am pleased that this review has already begun. However, I would like to make several suggestions that I feel may be helpful in resolving some of these problems now facing the VA and the women veterans.

First, I would recommend an extensive mailing of questionnaires to all identifiable female veterans. The questions submitted for mailing should be structured to enable the VA to identify both positive and negative opinions on VA medical care, and the veteran should be asked to name specific facilities involved, whether for complaint or compliment.

Also, most VA Regulations (VAR) and laws (Title 38, USC) are clear, however, as changes occur it will be necessary to ensure that any modifications in regulations/laws are also made clear.

Additionally, the Veterans Administration needs to ensure that any complaints regarding inadequate treatment or sexual abuse/misconduct by any VA personnel must be investigated and appropriate actions taken. This should be preceded by strict clarification of laws regarding the presence of female attendants during examinations and that non-compliance will not be tolerated. With this, any laws regarding sexual abuse of patients should also be made clear to all physicians.

For some time, many women have been sent to contract facilities for medical care unavailable at VA (particularly gynecology). I suggest that a survey be made to obtain the cost factor involved in this procedure. Also some hospitals have civilian consultants or part time physicians (usually for gynecology) for a clinic every few weeks or for emergencies. The actual costs of this procedure should also be included in the survey.

I would also suggest a Hot-Line and/or women's counselor in each Veterans Administration facility. This would open communication and allow a flow of information to many women veterans that has not been available until now.

Finally, since I mentioned earlier that many women veterans are unfamiliar with the entire VA system, I would recommend a series of public service announcements, advertisements and pamphlets that would be directed toward the woman veteran.

I would like to close by stating that many women veterans do not wish to be segregated from the male veteran or from the Veterans Administration. Nor do they wish to seek medical care outside of the VA (unless there is obvious geographical problems). But it will take some time for the woman veteran to adjust to the VA even if new programs and ideas are implemented. However, in time I feel most women will be receptive, when the proper steps are taken.

I will conclude by asking you to remember that women veterans have a long and proven history serving their country within the military ranks. They stand proud as any other veteran and just as patriotic. Their right to treatment and benefits should be equal to all other veterans.

Again, Mr. Heilman, I wish to thank you for the opportunity to express my opinions and suggestions on these issues, and I hope that this information will be of value to you.

If I may be of any other service in this matter, please do not hesitate to contact me.

Sincerely,

ALBERTA I. SURESCH,
National Service Officer.

[For release Mar. 3, 1983, U.S. General Accounting Office]

STATEMENT OF ROBERT A. PETERSON, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION

Mr. Chairman and members of the subcommittee, we are pleased to be here today to discuss our September 1982 report[1] on female veterans' access to Veterans Administration (VA) health benefits.

VA health care programs have typically been oriented to male health care needs because most veterans are male. The need to plan for and provide medical care that meets the special needs of female veterans is becoming more important in view of the increasing numbers of female veterans coming into the system now and anticipated in the future. While representing only about 3.8 percent of all veterans, the female veteran population is growing significantly and women are expected to make up 12 percent of the military strength in 1984.

INPATIENT CARE

Because of the lack of privacy at older VA facilities, women, including those with service-connected disabilities, could not obtain some specialized medical care. Although staff and patients were sometimes inconvenienced, medical-surgical facilities were generally able to handle the current number of female patients. However, psychiatric facilities and domiciliaries were not.

Problems in insuring privacy at older medical centers created concerns for female patients and incovenienced the staff. Wards in older facilities have many 8- to 16-bed rooms and frequently have communal shower and toilet facilities. Five of the seven medical centers visited had bedrooms for 8 to 16 patients, and four of these had communal bathing areas. Because there often are not enough female patients to fill large rooms, females had to compete with isolation patients for the hospitals' limited number of private rooms.

Women could not participate in some treatment programs at two of the six psychiatric facilities we contacted. For example, women were not admitted to two specialized treatment programs at the Brentwood, California, VA medical center because they could not be assured adequate privacy. According to Brentwood's chief of psychiatry, staffing changes were made in May 1982 to permit women to be admitted to one of the two programs. VA's director of mental health told us that, in general, VA's older psychiatric hospitals are not suited to integrated treatment of men and women.

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[1] "Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits" (GAO/HRD-82-98, Sept. 24, 1982).

Neither service-connected nor nonservice-connected female veterans were admitted to 10 of VA's 16 domiciliaries because of a lack of privacy in sleeping and toilet facilities. VA has recognized the problem and has required domiciliaries that do not accept females to include in their 5-year renovation plans, modifications designed to accommodate women. Until renovations are completed, women needing domiciliary care may apply either to the 6 VA domiciliaries that accept women or to the 38 State veterans' home domiciliaries.

GYNECOLOGICAL AND OBSTETRICAL CARE

Women require gynecological and obstetrical care. However, women with nonservice-connected disabilities could not always get gynecological care, and women with normal pregnancies could not obtain obstetrical care.

Pelvic examinations and pap smears are important techniques for detecting cancer in women. However, only one medical center we visited, Syracuse, had reviewed patients' medical charts to monitor the completeness of female patients' physical examinations. This facility found that, in May and June 1981, pelvic examinations had been done for only 27 percent of the female patients; breast examinations for only 40 percent; and pap smears for none. At two other facilities, Houston and San Francisco, medical staff acknowledged that pelvic examinations were not routinely done.

At six of the medical centers visited, medical staff said that pelvic examinations were left to the physicians' descretion. At the other facility, the staff believed that pelvic examinations were always done, but said that there had been no monitoring of physicians' practices.

VA medical centers and independent oupatient clinics used various methods to provide gynecological care. While most facilities satisfactorily served female patients, 7 of 23 VA facilities contacted depended primarily on the fee-basis program to provide outpatient gynecological care. Because of restrictions on the availability of fee-basis care, nonservice-connected women were not eligible for outpatient gynecological treatment at these facilities even if the treatment was needed to obviate the need for hospitalization.

We have long encouraged sharing of Federal medical resources between VA and the Department of Defense (DOD) as a way to better use Federal facilities and thus reduce health care costs. One method the VA facilities could use to provide care to nonservice-connected female veterans is sharing agreements with military hospitals. Such sharing is now authorized under the Federal Interagency Medical Resources Sharing and Coodination Act of 1981 (Pub. L. No. 97-174). Because DOD hospitals have traditionally provided care to spouses and dependents, they are more attuned to the needs of female patients. Accordingly, we believe VA could expand its ability to meet female veterans' needs through sharing agreements with DOD hospitals.

FACILITY PLANNING

VA has not adequately considered the increasing female veteran population in long-range planning for construction and renovation projects or in designing facility renovations.

In October 1981, VA established a Medical District Initiated Program Planning process to develop 5-year plans. The initial phase, completed in March 1982, required medical centers to identify factors limiting service delivery. Although female veterans do not have access to some VA facilities and treatment programs, none of the 28 medical district submissions identified any factors limiting females' access to VA medical centers or treatment programs.

Further, data submitted by the medical districts on the current and projected veteran population to be served reflected total veterans without a breakdown by sex. Without projections on the female population likely to seek VA health care, VA cannot determine if its facilities can accommodate future demand.

Facilities that are renovated to provide more patient privacy still may not be able to accommodate female veterans. VA's privacy standards do not insure that female patients are provided privacy in shower facilities. The standards, which are used in designing facility renovations, discuss how to provide privacy in communal and private bath facilities, but do not require separate facilities for male and female patients. For example, part of the domiciliary at the Hampton, Virginia, medical center was renovated in 1977-78 to improve privacy in sleeping quarters, but no change was made in the communal bathrooms. Because there are no private bathrooms for female veterans, the domiciliary did ot accept females even after the renovations.

READJUSTMENT COUNSELING

The Readjustment Counseling Program for Veterans of the Vietnam Era, a program established in 1979 to provide counseling to veterans having difficulty readjusting to civilian life, was specifically addressing female veterans' needs. The veteran counseling centers (vet centers) were training staff on female veterans' readjustment problems, compiling statistics on female veterans seeking help, and performing outreach to female veterans.

Despite the actions Va has taken to address female needs in the vet centers, women still face problems gaining acceptance at some centers. According to the director of the Readjustment Counseling Program and the coordinator of the program's western region, vet centers vary in their awareness of female veterans' needs.

RECOMMENDATIONS AND AGENCY ACTIONS

We made several recommendations to correct the deficiencies I just discussed and have been encouraged by the actions VA has initiated.

In a January 1983 circular, VA directed each medical center and outpatient clinic to develop and submit to central office by June 30, 1983, a written plan for the care of female veterans. The plans are to address, at a minimum: The definition of a complete physical examination for a female as including breast examination and pelvic examination; Provision of inpatient gyneocologic services for hospitalized female veterans as well as those in VA nursing homes and domiciliaries; Provision of outpatient gynecologic services to both service-connected and nonservice-connected veterans; and Referral procedures so that female veterans can receive necessary services currently unavailable at the medical center because of privacy considerations.

The circular also directs the facilities to review their current method of providing outpatient gynecological services and upgrade those needing improvement by June 1, 1983. The circular specifically states that reliance of fee basis care alone is not adequate.

Finally, the circular directs each medical center to examine admitting areas, outpatient clinics, and bed services to identify physical barriers, such as lack of privacy or bath facilities, that limit access of females to any program. Plans for correction of barriers are to be incorporated in the 5-year construction plan for fiscal years 1985 through 1989, unless the necessary renovations or new construction are underway prior to fiscal year 1985.

We believe the actions taken by VA, if effectively implemented, should significantly improve female veterans access to VA health care.

Mr. Chairman, this concludes my statement. We will be happy to respond to any questions you or members the Subcommittee may have.

SUMMARY OF STATEMENT

GAO has reviewed the Veterans Administration's (VA's) efforts to provide health benefits to femal veterans. Although progress has been made in insuring that medical care is available to femal veterans, action is needed to insure that: Men and women have equal access to VA treatment programs and medical facilities; Women treated in VA facilities receive complete physical examinations; Needed gynecological care is provided; and Sufficient plans are made for the anticipated increase in female veterans.

Actions VA has taken to implement our report recommendations should, if effectively implemented, significantly improve female veterans access to health care.

U.S. General Accounting office,
Human Resources Division,
Washington, D.C., September 24, 1982.

Subject: Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits (GAO/HRD-82-98).

Hon. Daniel K. Inouye,
U.S. Senate,
Washington, D.C.

Dear Senator Inouye: In response to your April 24, 1981, request, we reviewed the Veterans Administration's (VA's) efforts to provide benefits to female veterans. As agreed with your office, we focused on their medical needs. Specifically, we sought to determine whether VA was (1) equipped to provide them medical care, (2) planning for the anticipated increase in their demand for care, (3) informing them of available benefits, and (4) addressing their psychological problems related to service in Vietnam.

We visited 13 VA facilities, contacted another 32 facilities, and interviewed VA central office officials and representatives of veterans' service organizations. (Our objectives, scope, and methodology are detailed in enc. II.)

VA has made progress in insuring that medical care and other benefits are available to female veterans. However, because women make up only 2.5 percent (742,000) of the total veteran population, VA has not adequately focused on their needs. Yet, women have some unique needs, particularly medical, that must be addressed.

Action is needed to insure that: Men and women have equal access to VA treatment programs and medical facilities; Women treated in VA facilities receive complete physical examinations; Needed gynecological care is provided; Sufficient plans are made for the anticipated increase in female veterans; and female veterans are adequately informed of their benefits.

The primary mission of VA's medical care system is to provide care to veterans with service-connected disabilities. In addition, to the extent that staff and facilities are available, VA facilities can provide care for nonservice-connected disabilities to veterans who are unable to defray the cost of care elsewhere. VA facilities have traditionally been sized and staffed to provide care to both service-connected and nonservice-connected patients. In past reports, we have questioned whether VA should be sizing facilities to serve both categories of veterans. However, as long as VA continues to do so, it should insure equal access to care for female veterans.

Because of the lack of privacy in older VA facilities, women could not benefit from some specialized medical care. For example, women could not participate in certain treatment programs at 2 of 6 VA psychiatric facilities contacted and were not admitted to 10 of the 16 domiciliaries. In addition, although the medical surgical facilities could generally handle the number of female patients they had, the problem of insuring patient privacy at older medical centers inconvenienced patient and staff.

Although encouraged to do so by VA's central office, only one of the seven medical centers we visited had monitored physical examinations to insure that female patients received pelvic and breast examinations. That facility found that pelvic examinations had been documented for only 27 percent of the female patients, breast examinations for only 40 percent, and pap smears for none. Medical staff at two additional facilities told us that pelvic examinations were not routinely given.

Complete gynecological and obstetrical care were often not available. Va medical centers and independent outpatient clinics used various methods to provide gynecological care. While most were satisfactory, the reliance of many facilities on the fee-basis program—reimbursements to private health care providers—resulted in treatment being denied to women with nonservice-connected conditions. Eight of the 30 medical centers and independent outpatient clinics contacted depended primarily on the fee-basis program to provide gynecological care. However, VA can reimburse private sources for outpatient care only if the veteran is service-connected or has an emergency condition.

Thus, facilities that did not have outpatient gynecological services available and relied on the fee-basis program could not provide care to women with nonservice-connected, nonemergency gynecological problems. This was inequitable because the facilities treated virtually all outpatient medical needs of nonservice-connected males. For example, at the San Francisco medical center, 10 women were denied outpatient care for nonservice-connected gynecological problems during the first 5 months of fiscal year 1982, while the medical needs of men with nonservice-connected problems were routinely met.

VA does not provide care for normal pregnancy and childbirth, even if the veteran was pregnant when discharged from the military or is unable to pay for hospital care. Officials at six of the seven medical centers we visited said that female veterans had requested, but were denied, care for normal pregnancies.

VA has not adequately assessed its ability to meet the future needs of female veterans. VA's long-range planning has not (1) indentified programs currently unable to accept women or (2) projected the number of service-connected and nonservice-connected female veterans expected to seek care. VA has also not insured that renovation projects were planned so as to increase female patients' access to care.

Although VA is required to provide outreach services to veterans and measure the services' effectiveness, VA's outreach efforts have not been directed toward female veterans. VA has not (1) routinely disseminated information on benefit changes to service organizations with predominantly female memberships; (2) targeted outreach to female veterans, as it has for other categories of veterans; (3) adequately informed female veterans of statutory changes in their eligibility; or (4) measured female veterans' awareness of benefits, as it has for male veterans.

The Veterans' readjustment Counseling Program was, however, specifically addressing female veterans' needs. Staff from 108 of the 126 veteran counseling centers had been trained in counseling female veterans. The centers were also collecting statistics on the women treated, and some were performing outreach specifically toward female veterans.

Enclosure I details the results of our review. We are making several recommendations to the Administrator of Veterans Affairs to insure that (1) female veterans have equal access to VA medical programs, (2) they receive needed gynecological care consistent with VA policies on providing care to nonservice-connected veterans, (3) their needs are considered in future planning for construction and renovation projects, and (4) they are adequately informed of available benefits. (See pp. 15 and 16.) VA agreed with most of our recommendations. (See enc. III.)

As arranged with your office, we are sending copies of this report to the Administrator of Veterans Affairs; the Director, Office of Management and Budget; and other interestd parties. Copies will also be made available to others who request them.

Sincerely yours,

GREGORY J. AHART,
Director.

Enclosures.

[Enclosure I]

ACTIONS NEEDED TO INSURE THAT FEMALE VETERANS HAVE EQUAL ACCESS TO VA BENEFITS

In an April 24, 1981, letter, Senator Daniel Inouye requested that we review the adequacy of the Veterans Administration's (VA's) efforts to meet the needs of female veterans. Our review was performed in accordance with generally accepted governmental auditing standards as contained in the Comptroller General's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions." Our objectives were to determine whether VA was: Equipped to provide medical care to female veterans; Effectively planning for the anticipated increase in their demand for medical services; Adequately informing them of the benefits available; and Addressing their psychological problems through its Readjustment Counseling Program for Vietnam era veterans.

We visited 7 medical centers, 1 psychiatric hospital, and 5 veterans' readjustment counseling centers. We contacted another 23 medical centers and independent outpatient clinics, 5 psychiatric hospitals, and 4 domiciliaries. Further, we interviewed VA central office officials and representatives of veterans' service organizations. Our objectives, scope, and methodology are detailed in enclosure II.

BACKGROUND

As of September 1981, there were about 742,000 female veterans. While representing only 2.5 percent of all veterans, the female veteran population is growing significantly. Women made up only 2 percent of the military strength before 1975, but under the all-volunteer force, the percentage rose to nearly 6 percent in 1977 and is expected to reach 12 percent in 1984. According to a 1981 VA Professional Services Letter, the increasing female veteran population is already appearing in some geographical areas and in such medical programs as nursing homes and intermediate hospitals. Further, the letter states that "changes in the roles women are currently assuming in the military will impact the nature and kind of injuries they receive and the medical care they will require."

Veterans are eligible for a wide variety of benefits, including (1) assistance for education or training; (2) home loan guarantees; (3) medical services (including hospitalization, outpatient care, dental care, nursing home care, and drug and alcohol treatment); (4) compensation for service-connected disabilities; and (5) pensions for needy veterans who are premanently and totally disabled from nonservice-connected causes.

Although women have served in the military since at least World War I, they have not always received recognition as veterans and VA benefits equal to those given to male veterans. For example, women who serve in the Women's Airforces Service Pilots (WASPs) during World War II were not legally eligible for VA benefits until 1979.

Even when women were recognized as veterans, they were not given the same benefits as male veterans. For example, until 1972, married female veterans received smaller education allowances under the GI bill than did married male veterans. In the 1960s, VA did not consider a woman's income equal to a man's for the purpose of qualifying for home loan guarantees.

Although these inequities have been eliminated, VA health care programs have typically been oriented to male health care needs because most veterans are male. The need to plan for and provide medical care that meets the special needs of female veterans is becoming more important in view of the increasing numbers of service-connected female veterans coming into the system now and anticipated in the future. Women require care for breast disease, gynecological disorders, and pregnancy that may not be routinely available at VA hospitals. Privacy must also be provided in bed and bath facilities if male and female patients are to have equal access to VA treatment programs.

The primary mission of the VA medical care system is to provide care to veterans with service-connected disabilities. In addition, to the extent that staff and space are available, VA facilities can provide care for nonservice-connected disabilities to veterans who are unable to defray the cost of care elsewhere. Veterans with nonservice-connected illnesses are eligible for outpatient care only if the care is needed to obviate the need for hospitalization.

Veterans can also get care outside a VA facility. Veterans with service-connected disabilities can obtain both inpatient and outpatient care from private sources on a fee-for-service basis if VA facilities cannot provide the needed services or are geographically inaccessible to the veterans. Veterans with nonservice-connected disabilities are not generally eligible for fee-basis care. However, because some VA facilities cannot accommodate women, VA facilities can authorize fee-basis inpatient care for nonservice-connected female veterans.

Although nonservice-connected veterans are entitled to care only on a space-available basis, VA facilities have traditionally been sized and staffed to provide care to both service-connected and nonservice-connected patients. In 1980, about 89 percent of VA inpatient veterans were treated for nonservice-connected disabilities.

Past studies of VA programs and veterans have not adequately addressed the effectiveness of VA's programs in meeting the needs of female veterans. For example, a 1977 National Academy of Sciences' study [1] of the VA health care system specifically excluded female patients because the female veteran population was so small. Similarly, major studies of Vietnam veterans have not included women, although women served in Vietnam.[2] Furthermore, although some women have had Agent Orange examinations, the data compiled in VA's Agent Orange registry do not distinguish between male and female veterans. Thus, we could not readily determine the number of female veterans who have received these examinations or the incidence or type of medical problems they have experienced.

Similarly, other Federal sources of data on veterans have not included information on female veterans. Although the Bureau of the Census has collected data on male veterans regularly since 1910 and published such data since 1950, it did not collect data on female veterans until 1980. The National Center for Health Statistics has also published statistics on the size and characteristics of the veteran population but compiled data only on male veterans.

FEMALES' ACCESS TO PROGRAMS LIMITED BY PRIVACY PROBLEMS

Because of the lack of privacy at older VA facilities, women, including those with service-connected disabilities, could not obtain some specialized medical care. Although staff and patients were sometimes inconvenienced, medical-surgical facilities were generally able to handle the current number of female patients. However, psychiatric facilities and domiciliaries were not.

PSYCHIATRIC FACILITIES

Women could not participate in some treatment programs at two of the six psychiatric facilities we contacted. VA's director of mental health said that the six facilities were representative of other VA psychiatric facilities and that VA's older psychiatric hospitals are not suited to integrated treatment of men and women. He did not know how many of VA's psychiatric programs did not accept women.

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[1] "Study of Health Care for American Veterans," June 7, 1977, submitted to the Senate Committee on Veterans' Affairs.

[2] Data on the number of females who served in Vietnam were not available, but estimates ranged from 1,100 to 7,500.

Women were not admitted to the Intermediate Rehabilitation Unit or the New Directions Program at the Brentwood, California, VA medical center because they could not be insured adequate privacy. According to Brentwood's chief of psychiatry, privacy is inadequate in the sleeping areas, and VA cannot staff the units 24 hours a day to adequately supervise a sexually mixed population.

The Intermediate Rehabilitation Unit housed inpatients who no longer needed the structure of an acute psychiatric ward but who still needed treatment before returning to the community. Brentwood's chief of psychiatry estimated that annually about 15 to 20 women who could have benefited from the program remained in the acute psychiatric unit because they could not be accommodated in the rehabilitation unit. Because of this, the women could not benefit from (1) the less intensive supervision and (2) the emphasis on improving daily living skills, such as balancing checkbooks and finding housing, provided in the unit. However, according to the chief of psychiatry, in May 1982 Brentwood made the necessary staffing changes to permit women to be admitted to the unit.

Brentwood's New Directions Program, a highly structured, long-term treatment program for veterans with personality disorders, often compounded by drug or alcohol abuse, provides a restrictive environment emphasizing peer confrontation. According to the chief of psychiatry, from two to five women a year have been denied access to the program because VA did not have enough staff to supervise a sexually mixed psychiatric group. Women who could have benefited from the program were treated in either a general psychiatric ward or a substance abuse program, neither of which, according to the chief, were as effective in treating their personality disorders.

The chief of psychiatry said that the fee program could be used for female psychiatric patients who cannot be accommodated in VA programs. However, he said that there were no programs in California comparable to the New Directions or Intermediate Rehabilitation Unit programs.

The North Chicago VA medical center did not accept women in some of its psychiatric treatment programs. For example, a geriatric unit for frail elderly psychiatric patients who had complicating medical problems did not admit women because it could not provide adequate privacy to female patients. According to North Chicago's chief of psychiatry, about 10 female patients who could have benefited from the program's specialized nursing were being treated in other units. Similarly, a research unit that treated patients with tardive dyskinesia, a neurological disease that occurs more often in females than males, did not accept women. According to the chief of psychiatry, the unit did not provide adequate privacy in the sleeping areas, and because the facility had many more men than women with the disease, the women were treated in other psychiatric units. He said that about 20 women were therefore unable to benefit from the specialized nursing services and patient monitoring available in the research unit.

DOMICILIARIES

Neither service-connected nor nonservice-connected female veterans were admitted to 10 of the VA's 16 domiciliaries because of a lack of privacy in sleeping and toilet facilities. Domiciliaries provided care to ambulatory veterans disabled by age, disease, or injury who need care less intensive than hospital or nursing home care. VA has recognized the problem and has required domiciliaries that do not accept females to include, in their 5-year renovation plans, modifications designed to accommodate women. Until renovations are completed, women needing domiciliary care may apply either to 1 of the 6 VA domiciliaries that accept women or to 1 of 38 State veterans' home domiciliaries in 30 States.

However, the nearest facilities that accept women may be too far from the veterans' homes to be reasonable alternatives. For example, VA's Wadsworth, California, domiciliary, which does not accept female patients, is 400 miles away from the nearest alternative facility. Wadsworth officials estimated that each month five female veterans inquire about admittance to the domiciliary which serves the second largest concentration of veterans in the United States. They are directed to the three nearest domiciliaries that accept women: Temple, Texas, 1,500 miles away; White City, Oregon, 700 miles away; and Yountville, California, a State veterans' home domiciliary 400 miles away. VA officials said that most women do not pursue the alternatives because of a reluctance to move so far from their family and friends. In addition, the State domiciliary has a 5-year California residency requirement that some applicants may not meet. Both service-connected and nonservice-connected males can be accommodated at Wadsworth with little or no delay.

MEDICAL-SURGICAL CENTERS

Five of the seven medical-surgical centers we visited had problems accommodating female patients. In some, particularly older facilities with large open rooms, special procedures were required to accommodate females. The two newest facilities we visited, San Antonio and San Francisco, had no significant problems of this nature.

Problems in insuring privacy at older medical centers created concerns for females patients and inconvenienced the staff. Wards in older facilities have many 8- to 16-bed rooms and frequently have communal shower and toilet facilities. Because there often are not enough female patients to fill large rooms, females compete with isolation patients for the hospitals' limited number of private rooms.

Staff at five of the seven medical centers visited expressed concern regarding female patients' privacy either because of large open sleeping areas or communal baths or toilets. Five medical centers visited had bedrooms for 8 to 16 patients, and four of these had communal bathing areas. Concerns expressed by staff included:

Staff at three of the five facilities said that problems occurred when men had to be moved from private and semi-private rooms to make the rooms available for female patients. Problems mentioned included extra time demands on nurses making the moves, delays for women waiting to be admitted, and resentment on the part of the men being moved.

Nurses at Palo Alto said that, because women were admitted whenever possible to private rooms, originally intended as isolation rooms, they completed for these rooms with critically ill patients.

Staff at all five facilities cited problems with communal toilet or bathing facilities. When a female patient needed to bathe, nurses cleared the areas, then stood guard to insure privacy. Toilet facilities sometime had to be similarly secured, and nursing units at two facilities resorted to providing women portable commodes.

In addition, female patients were not always placed in the most appropriate medical ward. For example, a female alcoholism patient at Houston said that it took her 2 weeks to get transferred to a room on the alcohol treatment unit originally intended as a female patient's room. In the meantime, she was placed on the psychiatric ward and required to conform to that unit's more restrictive environment. She, therefore, felt that she was not treated the same as the male patients. Also, the fact that she had to make several complaints before she was moved put her in an adverary position with medical and administrative staff.

FULL GYNECOLOGICAL AND OBSTETRICAL CARE NOT ALWAYS PROVIDED

Women require some unique medical care, including pelvic examinations and gynecological and obstetrical care. However, physical examinations at the facilities visited did not always include pelvic examinations, women with nonservice-connected disabilities could not always get gynecological care, and women with normal pregnancies could not obtain obstetrical care.

PHYSICAL EXAMINATIONS

A January 1981 Va Professional Services Letter stated that: "A pelvic exam is a routine part of the physical examination for any female patient and should be required and monitored by each medical center's internal review program."

According to a VA gynecologist, pelvic examinations and pap smears are important techniques for detecting cancer in women. However, only one medical center we visited, Syracuse, has reviewed patients' medical charts monitor the completeness of female patients' physical examinations. This facility found that, in May and June 1981, pelvic examinations had been done for only 27 percent of the female patients; breast examinations for only 40 percent; and pap smears for none. These findings were provided to the hospital staff along with guidance on when such examinations are warranted. The hospital guidance stated that a breast examination should be done on every admission and that pelvic examinations and pap smers should be done annually unless there are specific indications to the contrary. A followup review is planned for 1982.

At six of the seven medical centers visited, medical staff said that pelvic examinations were left to the physicians' discretion. At the other facility, the staff believed that pelvic examinations were always done, but said that there had been no monitoring of physicians' practices. Medical staff at two facilities, Houston and San Francisco, said that pelvic examinations were not routinely done, although men generally received rectal examinations to detect prostate cancer.

GYNECOLOGICAL CARE

VA medical centers and independent outpatient clinics used various methods to provide gynecological care. While most facilities satisfactorily served female patients, many relied on the fee-basis program to provide gynecological care, which resulted in their denying treatment to nonservice-connected female outpatients. One method the facilities could use to provide this care to nonservice-connected veterans is sharing agreements with military hospitals.

Six of the seven facilities we visited had arranged to provide gynecological care to both service-connected and nonservice-connected outpatients:

The Manhattan VA medical center had a part-time gynecologist on its staff.

The Denver and San Antonio VA medical centers had sharing agreements with local universities to provide gynecological care.

The Palo Alto, Syracuse, and Houston medical centers had gynecology consultants under contract. Houston also had a gynecologist on its staff to see outpatients.

However, the San Francisco medical center relied exclusively on the fee-basis program for gynecological care and could therefore provide outpatient gynecological care only to service-connected patients or those with emergencies—the two categories of veterans permitted to receive outpatient fee-basis care under Federal law. As a result 10 women were denied outpatient care for nonservice-connected gynecological conditions at San Francisco during the first 5 months of fiscal year 1982. According to the medical center's administrative assistant for ambulatory care, some of the women had serious gynecological problems, but because they were nonservice-connected and did not need immediate hospitalization, they were denied care. San Francisco officials said that this reliance on the fee-basis program resulted in women being treated inequitably because virtually all outpatient medical needs of nonservice-connected male veterans were treated in VA's outpatient clinics to obviate the need for hospitalization.

To determine whether other facilities were relying on the fee-basis program to serve female veterans, we made a telephone survey of 17 randomly selected medical centers and all 6 independent outpatient clinics. Seven of these facilities indicated that they depended primarily on the fee-basis program to provide outpatient gynecological care. Because of restrictions on the availability of fee-basis care, nonservice-connected women are not eligible for outpatient gynecological treatment at these facilities even if the treatment is needed to obviate the need for hospitalization.

We have long encouraged sharing of Federal medical resources between VA and the Department of Defense (DOD) as a way to better use Federal facilities and thus reduce health care costs. Such sharing is now authorized under the Federal Interagency Medical Resources Sharing and Coordination Act of 1981 (Pub. L. No. 97-174). Because DOD hospitals have traditionally provided care to spouses and dependents, they are more attuned to the needs of female patients. Accordingly, we believe VA could expand its ability to meet female veterans' needs through sharing agreements with DOD hospitals. The San Francisco medical center was considering such a sharing agreement with a nearby military hospital to provide gynecological care.

In April 1982, legislation was introduced (S. 2385) that would authorize VA to provide certain outpatient care—pre- or post-hospitalization care and care necessary to obviate the need for hospitalization—on a fee-for-service basis for nonservice-connected disabilities of female veterans when VA is unable to provide care for their gender-related disability. According to the Chairman of the Senate Committee on Veterans' Affairs, he introduced the legislation to meet the needs of female veterans who cannot receive needed medical care because VA is not equipped to provide gynecological and other services they require for gender-specific conditions.

FEMALE VETERANS CANNOT RECEIVE CARE FOR NORMAL PREGNANCY

Under a VA regulation, female veterans are not eligible for medical care for normal pregnancy and childbirth, even if they were pregnant when discharged from the military or are unable to defray the cost of hospital care. The regulation was recently upheld in the U.S. Court of Appeals for the District of Columbia, but further litigation is possible. In the event that VA must eventually provide obstetrical care, we have identified several ways to provide such care without expanding VA facilities.

VA is required by law (38 U.S.C. 610) to provide hospital care to any veteran with a service-connected "disability" and, if space is available, to a veteran with a nonservice-connected disability who is unable to defray the cost of hospital care. However, VA considers normal pregnancy a physiological condition, not a disability. Accordingly, a VA regulation (38 CFR 17.48(e)) states that VA will not provide care for pregnancy unless it is complicated by a pathological condition. VA officials at six of the seven medical centers we visited told us that female veterans requested hospital care for normal pregnancies and were refused treatment. We did not obtain information on whether pregnant veterans had requested care at the seventh facility.

The VA regulation was challenged by a veteran, who claimed that childbirth is a disability within the meaning of the law. In 1981, the U.S. District Court for the District of Columbia ruled, in *Kirkhuff* v. *Cleland*, that the regulation was inconsistent with the intent of the law and was therefore invalid. However, on July 20, 1982, the U.S. Court of Appeals for the District of Columbia overturned the lower court's decision,[1] stating that the regulation was sufficiently reasonable "* * * in light of the legislative history, the wide-ranging responsibility and discretion of the Veterans Administration on matters dealing with benefits for veterans, and the longstanding, consistent, and widely publicized nature of VA's interpretation * * *."

As of August 30, 1982, the veteran had not appealed the decision.

VA has argued that it would have to expand VA facilities at great expense to provide obstetrical care; however, alternatives exist. VA provides hospital care for pregnacies with complications through arrangements with other facilities (for example, affiliated university hospitals) or through the fee-basis program. These alternatives, as well as sharing agreements with DOD hospitals, could be used to provide care for normal pregnancies.

VA PLANNING EFFORTS NOT ADEQUATELY CONSIDERING FEMALE VETERANS

VA has not adequately considered the increasing female veteran population in long-range planning for construction and renovation projects or in designing facility renovations. In developing data for VA's 5-year construction plan, VA medical centers did not identify the factors limiting female veterans' access to facilities and programs or project the number of service-connected and nonservice-connected female veterans expected to seek VA care. Furthermore, when detailed plans were developed for renovation projects, medical centers did not insure that the planned renovations would provide females adequate privacy.

A 1981 VA Professional Services Letter stated that because of the "increasing numbers of women veterans coming into the system * * * it [is] important to plan for and implement health care programs * * * tailored to the special needs * * * of women veterans." It suggested that "each medical center review its approach to female patients and determine what changes and adjustments may be needed."

However, VA planning has not identified medical programs that cannot accomodate female veterans. In October 1981, VA established a Medical District Initiated Program Planning process to develop 5-year plans. The initial phase, completed in March 1982, required medical centers to identify factors limiting service delivery. Although female veterans do not have access to some VA facilities and treatment programs, none of the 28 medical district submissions identified any factors limiting females' access to VA medical centers or treatment programs.

Furthermore, VA had not quantified the expected increase in female veterans' demand for VA services. To identify expected increases or decreases in demand for services, VA directed medical districts to include, in their January 1982 submissions, data on the current and projected veteran population to be served. However, the data submitted by the medical districts reflected total veterans without a breakdown by sex. One medical district recognized the need for data on female veterans, but indicated that such data were not available.

Without projections on the female population likely to seek VA health care, VA cannot determine if its facilities can accommodate future demand. As stated on pages 5 and 6, older Va facilities frequently use their few isolation rooms for female patients. As the number of female patients increases, these facilities may not be able to adequately accommodate female veterans.

VA's privacy standards do not insure that female patients are provided privacy in shower facilities. The standards, which are used in designing facility renovations, discuss how to provide privacy in communal and private bath facilities, but do not require separate facilities for male and female patients. as a result, facilities that are renovated to provide more patient privacy still may not be able to accommodate female veterans.

For example, the Syracuse medical center developed renovation plans—approved by VA's central office—that could give women access to more patient rooms but did not give them adequate access to shower facilities. Syracuse planned to divide the medical center's 16-bed rooms into smaller rooms equipped with toilets and sinks, but did not plan to subdivide existing communal showers or provide more private showers. Syracuse officials said that they had not recognized the potential future problem of shower privacy during the planning process. After our visit, they revised the plans to include private showers in some rooms to accommodate female patients.

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[1] Now *Kirkhuff* v. *Nimmo*.

Similarly, part of the domiciliary at the Hampton, Virginia, medical center was renovated in 1977–78 to improve privacy in sleeping quarters, but no change was made in the communal bathrooms. Because there are no private bathrooms for female veterans, the domiciliary did not accept females even after the renovations.

VA's domiciliary coordinator said that if renovations do not specifically address females' needs, the increasing number of retirement-age female veterans will place an additional burden on the six domiciliaries that accept women.

VC OUTREACH NOT DIRECTED TO FEMALE VETERANS

VA has not effectively informed female veterans of their benefits or assessed their awareness of those benefits. Specifically, VA has not (1) routinely disseminated information on benefit changes to service organizations with predominantly female memberships; (2) targeted outreach to female veterans, as it has to other groups of veterans; (3) adequately informed female veterans of statutory changes in their eligibility for benefits; or (4) measured female veterans' awareness of benefits.

VA is required to conduct outreach to inform veterans of available benefits and services. To do this, VA sends veterans letters a few months after discharge; distributes public service announcements and news releases to television networks, radio stations, newspapers, and magazines; operates veterans' assistance centers in VA regional offices to provide information on VA benefits to veterans who inquire; and distributes information to veterans' service organizations for dissemination to their members.

VA relies heavily on recognized service organizations to inform female veterans of VA benefits, but neither VA officials nor the service organizations knew how many women belonged to the organizations. All of the 90 VA-recognized service organizations have predominantly male memberships, and one of the major ones, the Veterans of Foreign Wars, did not admit women as members until 1978. VA automatically informs all VA-recognized service organizations of changes in benefits or in eligibility requirements, whereas nonrecognized organizations must request specific information. VA had made no special effort to get predominantly female veterans' groups, such as the Women's Overseas Service League or Women's Auxiliary Army Corps, to apply for recognition.

Although VA has targeted certain groups of veterans in its outreach program, it has done no special outreach toward female veterans. VA has made special efforts to inform educationally disadvantaged, aging, and incarcerated veterans of their benefits. For example, in fiscal year 1980, VA provided information on its services to over 600 local agencies serving aging Americans and conducted presentations at senior citizen centers, nursing homes, and congregate meal sites.

In addition, VA was not effectively notifying women of statutory changes in their eligibility. Although VA did outreach for one benefit change, it did not notify women of another major eligibility change and provided misleading information on a third change.

In 1975, VA did extensive outreach notifying female veterans of a change in GI bill education payments. VA notified female veterans of retroactive adjustments, going back to 1966, that equalized the benefits paid to married female veterans with those paid to married males.

In another instance, however, VA made no attempt to inform female veterans of a change specifically affecting them. Under the Equal Credit Opportunity Act of 1975, lending institutions are required to give the same weight to women's income as they do to men's when considering applications for home loans. Although VA was aware that lending institutions had been discriminating against females in processing home loan guarantees, it made no special efforts to inform female veterans that lending institutions could no longer discriminate on the basis of sex or require women to submit statements on their use of birth control.

Although VA recently attempted to inform several groups of newly recognized female veterans that they were eligible for VA benefits, it did not contact all members of the groups or provide accurate information. Several groups of women who provided services to the Armed Forces in a civilian capacity during World War II were judged by DOD to have served in an active duty military capacity and therefore became eligible for veterans' benefits. The two largest groups, the WASPs and the Women's Auxiliary Army Corps, recognized as veterans in 1979 and 1980, respectively, have an estimated current membership of over 7,000.

To become eligible for veterans' benefits, a member of these groups must apply to DOD for an official service discharge. Neither DOD nor VA has attempted to notify the women who have not applied for a discharge that they may be eligible for veterans' benefits. As of September 1981 about 2,500 of the 7,000 had applied for veterans' status.

VA has sent the same form letter that it sends to all recently discharged veterans to most of the 2,500 women who have received a service discharge. VA said that a specially designed and carefully worded letter and pamphlet were prepared to advise the newly recognized female veterans of benefits to which they may be entitle, but that the wrong letter was initially mailed to female veterans by mistake. According to VA, the specially designed letter has been sent to 859 female veterans recognized since September 1980. The approximately 1,600 female veterans recognized before that time were sent a form letter informing them that they were eligible for all VA benefits. However, the members of the two groups were not eligible for all those benefits. For example, they were not eligible for the GI bill education benefits, certain dental benefits, or job preference benefits. According to an official from the WASPs, because of this misinformation, some female veterans were confused about what benefit they were eligible for.

Although VA is required to assess the effectiveness of its outreach services, it has not measured their effectiveness in reaching female veterans. In 1980, VA issued the "1979 National Survey of Veterans," a major study of male veterans' awareness and use of VA benefits. The veterans in the study were selected from Bureau of the Census data, which identified only male veterans. The study showed that many male veterans were not aware of VA benefits. For example, of the selected male veterans,—78 percent were aware of VA hospitalization benefits;—46 percent were aware of the VA outpatient care; and—89 percent were aware of the VA home loan guarantee program.

Although VA is now studying female veterans' use of certain benefits, it has not studied their awareness of benefits and, therefore, does not have data to assess how well it is meeting its responsibility to inform all veterans of benefits.

VETERANS' READJUSTMENT COUNSELING PROGRAM ADDRESSING FEMALE VETERANS' NEEDS

The Readjustment Counseling Program for Veterans of the Vietnam Era, a program established in 1979 to provide counseling to veterans having difficulty readjusting to civilian life, was specifically addressing female veterans' needs. The veteran couseling centers (vet centers) were training staff on female veterans' readjustment problems, compiling statistics on female veterans seeking help, and performing outreach to female veterans.

According to the program's director, vet center staff at first did not consider women who served in Vietnam to be combat veterans. He said that, because of the small number of women who served in Vietnam and the different roles that men and women generally played, female veterans' readjustment needs were not initially recognized. However, training provided to vet center staff now recognizes the needs of female veterans. As of May 1982, the women's director of Vietnam Veterans of America and VA staff had trained staff from 108 of the 126 vet centers in counseling female veterans.

Of the five outreach centers we visited, two (Denver and Oakland) specifically targeted outreach to female veterans, one (Houston) publicized that the program served both male and female veterans, one (San Antonio) planned to do outreach to females, and one (Manhattan) did not discuss both male and female veterans in its outreach.

Despite the actions VA has taken to address female needs in the vet centers, women still face problems gaining acceptance at some centers. According to the director of the Readjustment Counseling Program and the coordinator of the program's western region, vet centers vary in their awareness of female veterans' needs. The director said that a vet center's attitude toward female veterans will reflect community values because both the staff and clients generally come from that community. According to the women's director of the Vietnam Veterans of America and several female veterans in California and Oregon, female veterans still encounter negative reactions from some VA staff and veterans.

CONCLUSIONS

Because of the high proportion of male veterans, the VA health care system has traditionally been oriented toward male needs. Although the primary mission of the VA health care system is to meet the needs of service-connected veterans, VA facilities have generally been sized and staffed to accommodate both service-connected and nonservice-connected veterans. Thus, male veterans can generally obtain needed care from a VA facility regardless of service connection. The same is not true for female veterans because of problems in insuring privacy in older facilities and variations in the availability of gynecological care. We have, in the past, questioned whether VA should size its hospitals to accommodate nonservice-connected veterans. However, as long as VA continues to do so, it should insure that male and female veterans have equal access to facilities and treatment programs.

VA needs to increase its staff's awareness of female veterans' unique medical needs and do more to address those needs. This is becoming more important because of the increasing numbers of female veterans and the increasing proportion of them who are expected to have service-connected disabilities. Without a concerted effort by VA to identify and address female veterans' needs, neither short-term renovation projects nor long-term facility planning will substantially increase their access to VA medical care.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the Chief Medical Director:

Improve female veterans' access to outpatient gynecological care and other care not available at VA facilities by (1) negotiating sharing agreements with DOD or other Federal hospitals, (2) contracting with private gynecologists, or (3) developing in-house capability.

Revise privacy standards and insure that future construction or renovation projects correct privacy limitations that limit women's access to VA facilities and treatment.

Instruct VA medical facilities to identify all treatment programs that cannot accept female patients and develop alternative ways to provide the care, such as sharing agreements or increased use of the inpatient fee-basis program.

Develop projections on the numbers of service-connected and nonservice-connected female veterans expected to seek care from VA and use such data in planning future construction and renovation projects.

We also recommend that the Administrator, through the Chief Benefits Director: Evaluate female veterans' awareness of benefits; Establish procedures to insure that female veterans will be notified of major changes in benefits that affect them; and Expand outreach efforts to include veterans' organizations with predominantly female memberships.

AGENCY COMMENTS AND OUR EVALUATION

VA agreed with our recommendations to improve female veterans' access to medical care, but did not agree that the primary mission of the VA system is to provide care to veterans with service-connected disabilities. VA also did not agree that there is a need for (1) an assessment of female veterans' awareness of VA benefits or (2) special efforts to notify female veterans of changes in their benefits

PRIMARY MISSION OF VA MEDICAL CARE SYSTEM

VA said that section 4101(a), title 38, United States Code, states unequivocally that "the primary function of the VA Department of Medicine and Surgery is to provide a complete medical and hospital service * * * for the medical care and treatment of veterans." (Emphasis added by VA.) VA also stated that, although nonservice-connected veterans are not eligible for all the medical care for which service-connected veterans are eligible and priority is usually given to service-connected over nonservice-connected veterans, one of VA's primary functions is to provide medical and hospital services to all eligible veterans.

The language cited by VA was added to 38 U.S.C. by the Veterans Omnibus Health Care Act of 1976, whose principal purpose was, according to the Senate Report, to "redirect care and expenditures to the system's primary beneficiaries—veterans with service-connected disabilities." The report also stated that:

"The VA hospital system since its establishment more than 50 years ago, has had as its primary mission the provision of first-class medical care to service-connected veterans. Its secondary mission has been to provide care for nonservice-connected veterans, but only to the extent that facilities are available so as to bring about a patient population size which could promote efficient utilization of resources." (Emphasis added.)

IMPROVE FEMALE VETERANS' ACCESS TO CARE

VA said that it will develop guidelines to help all VA health care facilities improve female veterans' access to out-patient gynecological care and other care not available to them at VA facilities.

REVISE PRIVACY STANDARDS AND INSURE THAT CONSTRUCTION PROJECTS CORRECT PRIVACY LIMITATIONS

VA said that, as guidelines and instructions for interim construction are revised, sensitivity to the special facility needs of female veterans will be highlighted and encouraged. According to VA, a forum will be developed through medical center engineering officer conferences and conference telephone calls to share successful local solutions to female patient care and privacy problems. VA said that health care facility construction will provide the special facilities needed to treat female veterans when VA's health care programs require these facilities. However, VA said that, because of existing physical constraints and limited resources, interim solutions are often necessary even though they require a compromise in program scope and staff convenience.

DEVELOP PROJECTIONS ON FEMALE VETERANS

VA said that it will prepare estimates which reflect the age, county of residence, and other statistics regarding the female veteran population. According to VA, the estimates will be used in conjunction with current age-specific utilization data to project future use.

EVALUATE FEMALE VETERANS' AWARENESS OF BENEFITS

VA said that our recommendation could be quickly implemented but questioned the need for our value of such information. According to VA, female veterans are, "first and foremost, veterans" and as such, have access to the full range of benefits information and assistance provided to all veterans. VA said that the assistance available to all veterans includes toll-free telephone service in all 50 States and access to any regional office for a personal interview.

Having access to information on available benefits does not mean that veteran is aware of those benefits or of the availability of benefits information. Although male veterans have access to the toll-free telephone lines and regional offices, VA studies have shown that male veterans are not aware of many of their benefits. We believe female veterans' awareness should be measured because (1) women have not been included in past VA studies and (2) they have not always received the same information and benefits as male veterans.

NOTIFY FEMALE VETERANS OF CHANGES IN VETERANS' BENEFITS SPECIFICALLY AFFECTING THEM

VA does not see a need to subdivide veterans by sex because (1) the same benefits are available to all veterans and (2) training at military separation points, briefings, and benefits orientations are all designed to disseminate comprehensive information regarding VA benefits and services. VA believes that separate procedures for female veterans are unnecessary and duplicative of ongoing procedures.

Benefits changes do not necessarily apply to all veterans. For example, legislation has been introducted to authorize fee-basis outpatient care for nonservice-connected female veterans when VA is unable to provide care for a gender-related disability. (See pp. 8 and 9.) If that legislation, or other legislation specifically affecting female veterans' benefits, is enacted, VA should insure that female veterans are notified of the changes. While training at military separation points would disseminate such data to newly separated veterans, it would not disseminate data to the 742,000 female veterans perviously separated.

EXPAND OUTREACH TO PREDOMINANTLY FEMALE VETERANS' ORGANIZATIONS

VA agreed with our recommmendation and said that action will be taken to ensure that veterans' organizations with predominantly female memberships are included in outreach efforts.

[Enclosure II]

OBJECTIVES, SCOPE, AND METHODOLOGY

Female veterans are increasing in both numbers and as a percentage of the total veteran population. Senator Daniel Inouye requested that we determine whether VA was (1) equipped to provide medical care to female veterans, (2) effectively planning for the anticipated increase in their demand for medical services, (3) adequately informing them of the benefits available to them, and (4) addressing their psychological problems through its Readjustment Counseling Program for Vietnam era veterans. Our study was conducted primarily at the following VA facilities in four States.

VA medical and psychiatric centers: San Francisco, Calif.; Palo Alto, Calif., (including nursing home); Brentwood, Calif. (psychiatric center); Denver, Colo., Houston, Tex. (including nursing home); San Antonio, Tex.; Manhattan, N.Y.; and Syracuse, N.Y. (including nursing home).

Veteran readjustment counseling centers (vet centers): Oakland, Calif.; Denver, Colo.; Houston, Tex.; San Antonio, Tex.; Manhattan, N.Y.

The facilities in California, New York, and Texas were selected because of the large numbers of female veterans living in those States. The Denver medical center and vet center were selected because a VA central office official indicated that they were particularly attuned to the concerns of female veterans.

ASSESSMENT OF MEDICAL CARE PROVIDED TO FEMALE VETERANS

To assess the capability of VA facilities to provide needed medical care to females, we determined whether (1) VA medical facilities and treatment programs were accessible to women, (2) gynecological care was available, (3) thorough physical examinations were given, and (4) obsterical care was available.

To determine if women had access to all VA medical facilities and treatment programs, at each medical center visited we interviewed VA personnel, including management and administrative personnel, nurses, physicians, and staff from the ambulatory care, psychiatry, and engineering services. We also toured all facilities to see whether they offered adequate privacy in the bed and bath areas.

Because psychiatric facilities were cited in the 1977 National Academy of Sciences study of VA health care as lacking adequate patient privacy, we visited the psychiatric facility at Brentwood, California, and contacted the chiefs of psychiatry at the Coatesville, Pennsylvania; Murfreesboro, Tennessee; North Chicago, Illinois; Fort Meade, South Dakota; and Salisbury, North Carolina, psychiatric hospitals to ascertain whether all treatment programs accepted women. According to the VA Director of Mental Health and Behavioral Sciences, the facilities contacted were representative of VA psychiatric facilities nationwide.

To determine whether women had access to VA domiciliaries, we spoke with VA's program coordinator for domiciliaries and officials at four domiciliaries (Wadsworth, California; Bath, New York; Hampton, Virginia; and Martinsburg, West Virginia).

To obtain information on VA policies and additional information on whether female veterans have access to all VA medical programs, we spoke with numerous VA central office officials from the Nursing, Medical, Professional, and Medical Administration Services; the Office of Administration; the Evaluation and Analysis Office; the Board of Veterans Appeals; the Reports and Statistics Service; the Extended Care and Patient Treatment Services; and the Inspector General's office.

To determine whether and how gynecological and obstetrical care were provided at VA facilities, we (1) spoke with the medical staff at each of the 7 medical centers visited, (2) conducted a telephone survey of 6 independent VA outpatient clinics and 17 randomly selected medical centers, (3) reviewed VA regulations and policies, (4) reviewed legal briefs concerning care for pregnancy, and (5) interviewed VA central office officials.

EVALUATION OF VA'S PLANNING FOR INCREASE IN FEMALE VETERANS

To determine whether VA was adequately considering existing facility limitations and numbers of female veterans in developing construction and renovation plans, we (1) interviewed VA central office officials in the Facility Planning Service, Health Systems Information Service, Office of Program Analysis and Development, Office of Construction, and Health Systems Planning Service; (2) reviewed all 28 VA medical district's initial submissions for the 1982 medical district initiated planning process; and (3) spoke with planners in two medical districts and with engineering and administration officials at the seven medical centers visited.

ASSESSMENT OF VA'S OUTREACH SERVICES TO FEMALE VETERANS

To assess the adequacy of VA's outreach to female veterans, especially outreach informing them of statutory changes affecting them, we spoke with VA officials and examined VA outreach material. At VA's central office, we (1) spoke with officials from the Office of Public and Consumer Affairs, Reports and Statistics Service, Department of Veterans Benefits, and Education and Loan Guarantee Services and VA's Federal Women's Program Manager; (2) viewed VA public service announcements distributed to television networks; (3) examined VA benefits brochures; and (4) reviewed VA studies on veterans' awareness of benefits.

To determine the effectiveness of veterans' service organizations as a vehicle for informing female veterans, we spoke with officials of veterans' groups, including the American Legion, Disabled American Veterans, Veterans of Foreign Wars, Vietnam Veterans of America, American Veterans Committee, Women's Overseas Service League, and WASPs.

At the medical centers, we spoke with staff about their perceptions of female veterans' awareness of benefits.

EVALUATION OF CARE PROVIDED TO FEMALE VETERANS BY READJUSTMENT COUNSELING PROGRAM

To determine whether the veteran readjustment counseling centers (vet centers) were addressing the needs of female veterans, we met with the program's director, the coordinator of the program's western region, and the women's director of Vietnam Veterans of America and listed five vet centers and spoke with their directors.

REVIEW OF NONMEDICAL BENEFITS

During the initial phase of our review, we spoke with VA officials about the availability of nonmedical benefits to female veterans. At the VA central office, we spoke with the Chief Benefits Director, Department of Veterans Benefits, as well as officials from the Education Service, Loan Guaranty Service, and Veterans Assistance Service. We also reviewed VA regulations on benefits, including the education, home loan, and compensation and pension programs. At VA's San Francisco Regional Office, we spoke with the regional Director and Loan Guaranty Officer about the regions' roles in providing benefits. In addition, we contacted some female veterans identified as having concerns about benefits to determine whether they believed they had been discriminated against.

Based on our initial work, we found little indication of inequitable practices in these programs; therefore, we focused on the health care programs.

[Enclosure III]

VETERANS ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, D.C., September 3, 1982.

GREGORY J. AHART,
Director, Human Resources Division,
U.S. General Accounting Office, Washington, D.C.

DEAR MR. AHART: My comments on the findings and recommendations in your July 21, 1982, draft report, "Actions Needed to Insure that Female Veterans Have Access to VA Benefits," are enclosed. Thank you for the opportunity to review this report.

Sincerely,

EVERETT ALVAREZ, JR.,
Deputy Administrator
(For Robert P. Nimmo, Administrator).

Enclosure.

VETERANS ADMINISTRATION (VA) COMMENTS ON THE GENERAL ACCOUNTING OFFICE (GAO) JULY 21, 1982 DRAFT REPORT, "ACTIONS NEEDED TO INSURE THAT FEMALE VETERANS HAVE ACCESS TO VA BENEFITS"

The following statements reflect my position on the recommendations in the subject report.

GAO recommends that I, through the Chief Medical Director:

Improve female veterans' access to outpatient gynecological care and other care not available at VA facilities by (1) negotiating sharing agreements with DoD or other Federal hospitals, (2) contracting with private gynecologists, or (3) developing in-house capability.

Instruct VA medical facilities to identify all treatment programs that cannot currently accept female patients and identify alternative ways to provide the care such as sharing agreements or increased use of the inpatient fee basis program.

I concur. VA Central Office staff will develop guidelines to assist all VA health care facilities in improving female veterans' access to outpatient gynecological care, and other care not available at VA facilities.

Revise privacy standards and insure that future construction or renovation projects correct privacy limitations that limit women's access to VA facilities and treatment.

I concur, and health care facility construction will provide the special facilities needed for the treatment of female veterans when the VA's health care programs require these facilities. As a result of existing physical constraints and limited resources, interim solutions are often necessary even though they require a compromise in program scope and staff convenience. As guidelines and instructions for interim construction are revised, sensitivity to the special facility needs of female veterans will be highlighted and encouraged. A forum will be developed through medical center engineering officer conferences and conference telephone calls to share successful local solutions to female patient care and privacy problems.

Develop projections on the number of service-connected and nonservice-connected female veterans expected to seek care from VA and use such data in planning future construction and renovations projects.

I concur in this recommendation and estimates will be prepared which reflect the age, county of residence, and other useful statistics regarding the female veteran population. These estimates will be used in conjunction with current age-specific utilization data to project future use.

GAO also recommends that I, through the Chief Benefits Director: Evaluate female veterans' awareness of benefits.

This recommendation could be quickly implemented but I question the need for or value of this information. Female veterans are, first and foremost, veterans. As such, they have access to the full range of benefits information and assistance provided to all veterans, including toll-free telephone service in all fifty states and access to any regional office for a personal interview.

Establish procedures to insure that female veterans will be notified of major changes in veterans benefits that affect them.

Again, I see no need to subdivide veterans by sex. The same benefits are available to all veterans. Additionally, training at military separation points, briefings, benefits orientations, etc., are all designed to disseminate comprehensive information regarding VA benefits and services. Establishing separate procedures for female veterans is unnecessary and duplicative of ongoing procedures.

Expand outreach efforts to include veterans organizations with predominantly female memberships.

I concur in this recommendation and action will be taken to assure that veterans organizations with predominatly female memberships are included in outreach efforts.

OTHER COMMENTS

Page 2 of your letter addressed to Senator Inouye and pages 3 and 23 of Enclosure I contain the statement that the primary mission of the VA medical care system is to provide care to veterans with service-connected disabilities. This is not an accurate statement. Section 4101(a), title 38, United States Code, states unequivocally that the primary function of the VA Department of Medicine and Surgery is to provide a complete medical and hospital service . . . for the medical care and treatment of veterans. (Emphasis added.) Although nonservice-connected veterans are not eligible for all the medical care for which service-connected veterans are eligible, and priorities are established which generally place service-connected ahead of nonservice-connected veterans, one of the primary functions of the VA is the provision of medical and hospital services to all eligible veterans.

Page 4 of the letter to Senator Inouye and pages 10, 14, and 15 of Enclosure I which discuss VA denial of care for normal pregnancies should be amended due to the recent D.C. Court of Appeals' decision in *Kirkhuff* v. *Nimmo* (No. 81-1770, D.C. Cir. July 20, 1982) which was favorable to the VA. The analysis of the alternative courses of action available to the VA can be deleted.

The statement on page 21 concerning form letters sent to newly recognized female veterans who had received a service discharge is misleading because it implies that the wrong form letter was sent in all cases. Initially, some incorrect letters were released in error. When VA receives verification of service, a specially-designed letter and VA Pamphlet 20-67-1 are mailed to these female veterans. The letter is carefully worded to advise the newly classified veteran of benefits to which she may be entitled. It was first mailed in September 1980 to 767 women. Ninety-two letters have been sent since the initial mass-mailing.

GAO note: Page references in this enclosure may not correspond to page numbers in the final report.

STATEMENT OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY VETERANS ADMINISTRATION

Mr. Chairman and members of the subcommittee, I am pleased to have the opportunity to discuss the Veterans Administration's provision of medical services to female veterans. At the outset let me assure you that the Veterans Administration is committed to providing equitable care to all veterans, male and female, and has made adjustments over the years to accommodate the special needs of female veterans.

Traditionally, the United States veteran population has been comprised almost exclusively of males. However, according to the 1980 census data, female veterans comprise 3.8 percent of the total veteran population in the United States and this proportion is expected to grow as the proportion of women in the armed forces continues to increase. The VA has experienced an increase in the use of VA medical facilities by women. From 1970 to 1982 the number of females discharged from VA medical centers increased from 9,619 to 16,560 or 1.7 percent of all discharges.

The VA has, of course, long been aware of the increasing number of women veterans and has taken this into account in its planning processes. VA policy has long provided for obtaining services on a fee basis or though other contractual arrangements if VA medical centers determine that available staff or consultants cannot render necessary services. To reemphasize this policy, a January 28, 1981, Information Letter was issued to remind all medical centers and outpatient clinics that they should take steps necessary to meet the special needs of female veterans. The letter also suggested methods of insuring that female patients receive quality services.

In September 1982, I directed that a survey of VA facilities be conducted to collect data for planning purposes regarding provision of medical services to female veterans. This survey showed that the majority of our facilities are currently providing adequate care for females and are using a variety of mechanisms to provide gynecologic care. In most cases, care for non-gender related conditions can be and is taken care of directly by the VA. I believe the findings of that survey will be helpful and we are making them available or our field facilities and planners.

As you know, Mr. Chairman, the General Accounting Office published a report entitled "Actions Needed to Insure that Female Veterans have Equal Access to VA Benefits," also in September 1982. Considerable notoriety surrounded the release of this report, and I regret some of the impressions which it triggered.

The report made a number of recommendations, many of which we were able to agree with in whole or in part. We were at that time taking actions that addressed concerns raised by GAO and considerable progress has since been made in implementing many of those recommendations. GAO's primary recommendations that were directed to the Department of Medicine and Surgery were:

Improve female veterans' access to outpatient gynecological care and other care not available to VA facilities by (1) negotiating sharing agreements with DOD or other federal hospitals, (2) contracting with private gynecologists, or (3) developing in-house capability;

Instruct VA medical facilities to identify all treatment programs that cannot accept female patients and develop alternative ways to provide the care, such as sharing agreements or increased use of the inpatient fee-basis program;

Revise privacy standards and insure that future contruction or renovation projects correct privacy limitations that limit women's access to VA facilities and treatment; and

Develop projections on the numbers of service-connected and nonservice-connected female veterans expected to seek care from VA and use such data in planning future contruction and renovation projects.

Several of the issues raised by the GAO report are addressed in a recent Circular (10-83-14, published January 28, 1983). The circular reemphasize to all VA medical facilities that planning for and providing comprehensive health services to female veterans is a priority goal for the VA. The fact that the circular details specific requirements for VA medical center action should in no way be taken to imply a broad-based need for remedial action. This circular was directed to a small number of facilities that have deficiencies. In this context the circular directs each center to evaluage the availability of its clinical services to provide comprehensive health care for female veterans. We have underscored the urgency of making any needed improvements or changes in a timely manner. The circular requires that a series of actions be taken to assure that equitable treatment programs and practices are available to female veterans. These include requirements that each center develop by June 1 a written plan for the care of female patients; review and upgrade, as needed, its gynecologic services; and correct privacy limitations. In particular, the plan for care to be developed at each center must include a series of elements:

1. Requirement for a complete physical examination for a female including breast and pelvic examination,
2. Provision of inpatient gynecologic services for hospitalized female veterans as well as those in VA nursing homes and domiciliaries.
3. Provision of outpatient gynecologic services so that all female veterans are able to receive care for gender-related conditions on a par with the care male veterans receive for their gender-related ailments, and
4. Referral procedures so that female veterans can receive needed services currently unavailable at the medical center because of privacy considerations.

Our recent circular also highlighted the importance of insuring adequate privacy for female patients, which may be a problem in our older facilities. We stressed this point notwithstanding the findings of our recently-completed survey of 160 VA medical centers which revealed, for example that over 80 percent of bed services reported that they had no problems in providing adequate privacy for the care of females on their wards. Our circular directs each medical center to examine admitting areas, outpatients to any program. We have directed our medical centers to begin necessary renovations or new construction prior to fiscal year 1985 using available Maintenance and Repair funds or incorporate plans for such corrections into the fiscal year 1985–1989 Five-Year Facility Plans.

We anticipate that these initiatives will provide the catalyst to accelerate progress in this area. Is is important, in my judgment, to note that the majority of our facilities presently have the means to meet the medical care needs of female patients. For example, in 1973 VA nursing homes were first required to accept eligble females, and at present, 86 percent of all nursing homes report that they can adequately provide for female patients. I believe our recent efforts will help us broaden our service capability and assure that female veterans have equal access to care. We will certainly strive to continue to make needed improvement in a timely manner.

Mr. Chairman, we would be remiss if we did not note that the GAO also reviewed the Readjustment Counseling Program and was generally complimentary of VA actions to address female veterans' needs. The Readjustment Counseling Service (RSC), which is made up of 136 Vet Centers, has several Vietnam-era veteran women who serve as team leaders. From its inception the readjustment counseling program has made a concentrated effort to encourage female veterans to utilize these services. To that end, our Vet Center teams have been sensitized to the needs of female Vietnam veterans during local and regional training sessions. In my judgment, these teams have been effective in addressing the needs of these veterans.

Mr. Chairman, you also requested that we testify today on H.R. 1137, a bill "To amend title 38, United States Code, to establish the Veterans Administration Advisory Committee on Women Veterans."

H.R. 1137, if enacted, would require the Administrator of Veterans Affairs to establish and maintain, until terminated by law, an advisory committee on women veterans. It mandates the appointment from among members of the general public of representatives of women veterans, authorities on the health care and other needs of women veterans, and representatives of male and female veterans with service-connected disabilities. It also requires the appointment to the committee of the Secretaries of Labor and Defense and the Chief Medical Director and Chief Benefits Director or their designees. The measure would limit any appointee's term of service to a three-year period. The Administrator would be required to consult with and seek advice from the committee on a regular basis on the administration of VA benefits to women veterans and on the unique needs of women veterans with respect to compensation, health care, and rehabilitation. Further, the committee would be required to furnish the Administrator at least biannually a report, including recommendations, on VA programs and needs pertaining to women veterans. The Administrator would be required to submit each report to Congress.

In essence, H.R. 1137 seeks to codify a decision which is more appropriately left to administrative discretion and which in fact has already been made within the VA.

Additionally, provisions of the bill are, in our view, unnecessarily restrictive and may hinder our efforts to accomplish the bill's purposes. For these reasons, we oppose the enactment of H.R. 137.

We agree in principle with what appears to be the major purpose underlying H.R. 1137—the desirability of providing the Administrator a broad spectrum of views to assist the Agency in planning to meet the needs of women veterans. However, we cannot agree with the premise that legislation is necessary or desirable to accomplish this. The Administrator of Veteran Affairs has broad authority to obtain advice and assistance in planning and administering the Agency's programs. In fact, shortly after his confirmation, the Administrator directed VA department heads to take steps to facilitate the administrative establishment of an advisory committee on women veterans. A measure such as H.R. 1137, which mandates the establishment, mission, general composition, duration, reporting requirements, and mode of operation of an advisory committee, deprives this Agency of the discretion and flexibility so important to sound program administration. Instead of a flexible tool to respond to Agency needs, the advisory committee to be established by H.R. 1137 represents a mechanism which, in its rigidity, could actually prove a greater burden than a benefit.

In summary, we oppose H.R. 1137 because we believe it unnecessarily restricts the Administrator's discretion to administer programs entrusted to his care.

This concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the committee may have.

SUPPLEMENTAL MATERIAL SUBMITTED FOR THE RECORD BY THE VETERANS ADMINISTRATION

GYNECOLOGIC CARE

Inpatient gynecologic care is available on a fee basis. Outpatient care is available to veterans who are less than 50 percent service-connected only to obviate hospitalization. This is true for male gender related conditions as well as female gender conditions.

NEW DIRECTIONS PROGRAM—BRENTWOOD VA MEDICAL CENTER

The New Directions program is a pilot program which is not available at other VA medical centers, and therefore is not available to males in other areas of the country. Furthermore, there is no hard evidence to prove that it is more effective than other more traditional treatment programs.

PRIVACY STANDARDS FOR MALES AND FEMALES

Most veterans' hospitals are not alike. The newer ones are built to conform to modern privacy standards for males and females. Some of the older ones reflect a World War II and earlier view of privacy with communal sleeping and bathing arrangements. These are being renovated.

DENVER VA MEDICAL CENTER AND VET CENTER FACILITIES FOR FEMALE VETERANS

The GAO included the Denver VA Medical Center and Vet Center in their study because "a VA Central Office official indicated that they were particularly attuned to the concerns of female veterans." We can only assume that they found this to be the case since the only other times Denver was mentioned was to describe their sharing agreement with a local university to provide gynecologic care and to cite the Vet Center as specifically targeting outreach to female veterans.

ELIGIBILITY FOR CONTRACT FEE FOR FEMALE VETERANS

Female veterans have the same basic eligibility for medical care as do male veterans for both inpatient and outpatient or ambulatory care services. In addition, certain eligibility provisions are unique to female veterans.

Female veterans needing hospitalization for either service-connected or nonservice-connected conditions may be authorized inpatient care at a non-VA facility if VA and other government facilities are incapable to furnishing the hospital care they need.

They have no special eligibility for fee basis care, but like male veterans they may be placed on fee-basis for post-hospital care of nonservice-connected conditions for which they received VA hospital care. (M-1, Part 1, Chapter 17, Paragraph 17.24).

Veterans Administration Regulation 6048(E) excludes entitlement to care for pregnancy or parturition unless complicated by a pathological condition.

SOCIAL WORKERS IN VA MEDICAL CENTERS AND OUTPATIENT CLINICS

The Veterans Administration employs over 3,000 social workers in 226 VA medical centers and outpatient clinics. All VA medical centers have departments of social work which provide the full range of social work services to patients.

DIRECTIONS TO THE FIELD

The January 1981 communication to the field was a Professional Services Informational Letter which provides guidance but does not mandate action. It is recommended that adequate examinations should be done and monitored. The January 1983 communication is a circular and contains requirements with which the VA medical centers must comply. Furthermore, the Systematic External Review Program (SERP) will address the access of females to the facility, adequacy of physical examinations and long-range planning for female veterans beginning with the March visits.

VETERANS ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., April 22, 1983.

Hon. JOHN PAUL HAMMERSCHMIDT,
Committee on Veterans' Affairs, House of Representatives, Washington, D.C.

DEAR MR. HAMMERSCHMIDT: Thank you for the opportunity to respond to the questions for the record of the March 3, 1983, hearing on VA Health Care for Women Veterans. I am pleased to provide you with the enclosed answers. If additional information is desired, please do not hesitate to contact me.

Sincerely,

DONALD L. CUSTIS, M.D.,
Chief Medical Director.

Enclosures.

Question. 1. Dr. Custis, are you able to comment upon my opening statement with respect to amending the law to allow contracting for outpatient treatment for women veterans in those cases where VA hopitals have no capacity or limited capacity for such treatment?

Answer. DM&S Circular 10-83-14, dated January 28, 1983, directs all VA medical centers and outpatient clinics to develop by June 1, 1983, a written plan for the provision of medical services, preferably through the enhancement of their in-house capability, to female veterans and to address in particular the provision of care for gender-related conditions so that eligible female veterans are able to receive care on a par with male veterans. The circular emphasizes that fee-basis care alone is not adequate because this limits the service primarily to service-connected female veterans.

We do not believe that additional legislation to allow the VA to authorize fee-basis care for female veterans being treated on an ambulatory care status to obviate the need for hospitalization is either needed or desirable. To enact such legislation would create an inequity in the VA's delivery of ambulatory care to male and female veterans.

Question. 2. Dr. Custis, you apparently are about to receive approximately $75 million for maintenance and repair of VA hospitals. Could part of this money be used to carryout the GAO recommendations with respect to construction projects designed to make VA facilities more accessible to women veterans?

Answer. Maintenance and repair funds may not be used for construction, however, specific major and minor construction projects are being identified which will correct the remaining physical barriers, such as lack of privacy or inadequate facilities, that limit access by female veterans. These projects will be included in the fiscal year 1985-1989 five-year facility plans.

Question. 3. Dr. Custis, we have heard testimony today that in the minds of some perhaps post-traumatic stress syndrome is not really identified with respect to women veterans. Can you elaborate on this?

Answer. Women veterans suffer from the same general types of mental stress and mental illness as males, although there may be some difference in the percentage afflicted. We have had women veterans suffering from post-traumatic stress disorder in our psychiatric services. We have no information on the comparative incidence of post-traumatic stress disorder among women and men.

Question 4. Dr. Custis, in your Psychological Readjustment Centers, are you satisfied that women veterans are being treated properly and that the counselling center employees understand the special problems which these women may have?

Answer. The number of females in the veteran population is growing. The recently released 1980 census figures indicate there are now 1,108,000 female veterans in the United States.

As you know a recent GAO study indicated the Vet Center program was doing a very good job in addressing the needs of female Vietnam-Era veterans. Our Readjustment Counseling Program has also implemented a comprehensive traning/awareness program geared to sensitizing our Vet Center staff on the special needs of our female veterans. This training/awareness initiative will continue.

Question 5. Dr. Custis, you oppose a statutory Advisory Committee on Women Veterans in part because you want to do the same thing administratively? What real difference would there be—if any—in these two methods of establishing such a committee?

Answer. We agree in principle, as we have said, with the desirability of providing the Administrator with a broad spectrum of views to assist the Veterans Administration in planning to meet the needs of female veterans. The main problem with a statutory committee is its inflexibility which we feel would interfere with its ability to respond to agency needs. Some statutory committees have interpreted their congressional mandate as autonomy to determine their agenda, set priorities and use scarce resources in a manner which becomes a burden instead of a help to the agency. We feel that you have made Congressional interest in the needs of female veterans clear. We would like the opportunity to take the initiative in this important area consistent with both sound management principles and our commitment to providing equitable care to all eligible veterans, male and female.

Question 6. Dr. Kinzer, I note you are Special Assistant to Administrator Walters, and I believe you were formerly working at the Pentagon. Would you mind reviewing for the Committee your qualifications for your present position?

Answer. Dr. Nora Scott Kinzer, Special Assistant to the Administrator of Veterans' Affairs, 810 Vermont Avenue, NW., Washington, DC 20420.

In her current position, Dr. Kinzer's responsibilities include the special needs and interests of women veterans. Previously, Dr. Kinzer was Deputy for Human Resource Management in the Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs. She dealt with manpower issues affecting the U.S. Army such as: education programs ranging from high school completion through graduate school; drug and alcohol abuse programs; family programs; child-care programs; family housing; clubs, commissaries, and post exchanges; morale, welfare, and recreation programs; dependent school issues including impact aid; chaplains; Armed Forces Radio and Television; Army community services; consumer affairs; and many other issues that impact on the recruitment and retention of enlisted soldiers and officers.

As Visiting Professor of Human Resource Management at the Industrial College of the Armed Forces, Dr. Kinzer taught courses on executive personnel development, management, military sociology, business ethics, communication, mobilization, and military manpower.

Dr. Kinzer is the author of three books, including Stress and the American Woman (Ballantine 1980), numerous book chapters in Spanish and English, and has published widely in professional journals and popular magazines such as Psychology Today and the Saturday Evening Post.

Prior to joining the National Defense University, Dr. Kinzer was a Senior Research Scientist with the Department of the Army Institute for the Behavioral and Social Sciences (1974-1977). She developed and analyzed scientific research to assess the recruitment, retention, and promotion of enlisted personnel officers of the U.S. Army. Dr. Kinzer served as liaison with and co-director of Project Athena of the Office of Military Leadership, United States Military Academy, West Point. Project Athena dealt with socio-psychological factors associated with the integration of women into the cadet corps of West Point. While at the Army Research Institute, Dr. Kinzer spent the summer of 1977 working on a task force for the establishment of the Office of Human Goals of the Veterans Administration.

While an Assistant Professor at Purdue University (1965-1974), Dr. Kinzer taught courses in Anthropology, Sociology, and Criminology. She gave many keynote addresses and seminars throughout the United States, Europe, and Latin America dealing with the subjects of Sociology, Medical Sociology, Latin American Studies and Anthropology. As representative of Purdue University to the Indiana Higher

Education Television Services, she devised a breakthrough town meeting program linking civic groups throughout the state.

Dr. Kinzer was one of the first Fellows of the Fletcher School of Law and Diplomacy's Latin American Teaching Fellowship Program. While conducting research in Buenos Aires, Argentina, she taught at the Jesuit University of El Salvador and was a Research Fellow at the Torcuato de Tella Institute.

Dr. Kinzer received her BA in Spanish from the University of Toronto. After a year's study at the University of Madrid, she received her Master's Degree in Spanish language and literature from Middlebury College, Vermont. Her Ph.D. in Sociology is from Purdue University. Dr. Kinzer is fluent in Spanish and French. She is married to a Hispanic and is the mother of four boys. Her oldest son is a student at the Citadel in Charleston, South Carolina.

Dr. Kinzer is active in civic and community affairs. She is a member of various professional organizations including the American Sociological Association. She is a Fellow of the Inter-University seminar on Armed Forces and Society. Her other activities include Boy Scouts and local PTAs. Dr. Kinzer is a lay reader and active member in her Episcopal church.

STATEMENT OF PHILIP R. MAYO, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the subcommittee, on behalf of the 1.96 million members of the Veterans of Foreign Wars of the United States, the opportunity to present our views to this distinguished Subcommittee regarding HR 1137, legislation introduced by you, to create in the Veterans Administration (VA) an Advisory Committee on Women Veterans and the General Accounting Office Report entitled "Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits" is greatly appreciated.

Initially, Mr. Chairman, we commend the Subcommittee for its decisive actions during the 97th Congress, actions which led to the passage into law of a number of measures that will help preserve high quality health care in the VA hospital system and which will promote the resolution of a number of health related problems experienced by Vietnam veterans.

In that same vein, the Subcommittee is considering HR 1137, which would authorize the establishment, as a permanent entity, an Advisory Committee on Women Veterans in the VA. The measure stipulates that the composition of the Committee be:

1. Members of the public appointed by the Administrator, including: (a) Representatives of women veterans; (b) Individuals of recognized expertise in health and other matters related to women veterans; (c) Representatives of both male and female veterans with service-connected disabilities;
2. The Secretary of Labor or his appropriately determined designee;
3. The Secretary of Defense or his appropriately determined designee;
4. The Chief Medical Director and the Chief Benefits Director or their designees.

The measure also requires that the VA regularly consult with the Committee on the needs of women veterans and that no later than July 1, 1984, and each second year thereafter, report to the Administrator their findings on the VA's activities as they pertain to women veterans, with the report being forwarded on to the Congress.

Mr. Chairman, the VFW supports the timely enactment of HR 1137. We would, however, recommend that the Subcommittee insert language into the measure that would ensure representation on the Committee of wartime veterans women and men. We consider it, also, appropriate that the Committee be chaired by and include as many women veterans as possible; that a more certain meeting schedule be established than is currently provided for.

Demonstrating the need for the above legislative initiative, Mr. Chairman, is the recent report of the GAO. In summary, the GAO found there existed in the VA medical care system:

1. Inadequate arrangements for privacy for women—particularly in sleeping and hygenic facilities;
2. Incomplete physical examinations—the absence of routine and appropriate gynecological procedures, tests;
3. Inequitable outpatient and fee-basis care;

And recommended that:

1. Women veterans needs be appropriately addressed in medical facility construction and renovation;
2. Women be appropriately informed of available benefits.

While we agree with the findings and recommendations of GAO, we would observe that GAO also indicates that the VA is showing positive progress in properly administering to women veterans, particularly in the Readjustment Counseling Program.

Mr. Chairman, the fact that we field a National Military establishment encompassing increasingly greater female participation demands that our perspective relative to the outcome of such service properly accommodate the health and benefits needs generated by that service. To do less is untenable; we commend this Subcommittee for its leadership in this endeavor. We believe no veteran should suffer inadequate or inequitable treatment, and that, if necessary, the VA should effect suitable arrangements with the military services or on a fee-basis to ensure proper care where its own resources and facilities cannot.

[Subsequently, the Veterans' Administration furnished three recent statistical publications for the record:]

Veterans
Administration

Statistical Brief

The Female Veteran Population: An Overview of Its Growth in the Last Decade

INTRODUCTION

Historically the U.S. veteran population has been comprised almost exclusively of males. Even today, about 97 of every 100 ex-service personnel in civil life are men. The 1970's, however, may have marked the beginning of a slow transition period with regard to the role that women play in the size of the veteran population. Whereas the number of male veterans has now started to decline, the count of females is growing rapidly. The share of all active duty military personnel that women constitute is also on the rise, thus indicating that the future will undoubtedly continue to bring increasing numbers of female veterans into civil life. Knowledge of trends like these is essential to the Veterans Administration (VA) to best address the needs of all members of the living veteran population. Effective management of the wide range of VA programs is greatly enhanced when a detailed profile of the veteran population is at hand.

DATA ANALYSIS

In the following sections, current and historical data on female veterans is compared to information on male veterans. Particular emphasis is given to the age composition of each of these population subgroups, as well as to the distribution of veterans by period of military service. All data are examined in light of what implications may be drawn for the future.

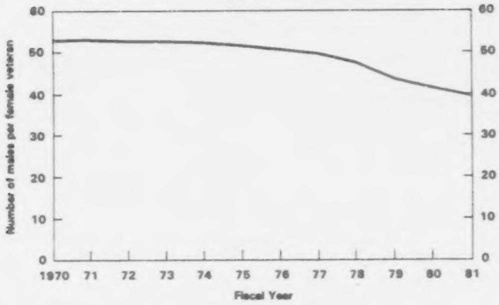
Female Veterans in Total

Women who are former members of the U.S. armed forces totalled 742,000 on September 30, 1981, or 2.5 percent of all living veterans. Even though the proportion of the total veteran population accounted for by females has grown only slightly since 1970, when it stood at 1.9 percent, the absolute number of female veterans has increased markedly during the last 11 years. This group of veterans has registered particularly significant expansion over the last five years when the total count of female veterans grew by 26 percent. This rather pronounced growth in the count of female veterans since the mid-1970's becomes even more apparent when comparisons are made with the number of male veterans. Chart 1 displays over time, the count of male veterans for every living female veteran. This ratio stood at just over 50 to 1 during the first half of the 1970's but dropped to 39.5 to 1 by the end of September 1981.

SB 70-82-1
March 1982

Office of Reports and Statistics
Statistical Policy and Research
Service
Research Division (711)

Chart 1. Ratio of Living Male to Female Veterans, FY 1970-1981

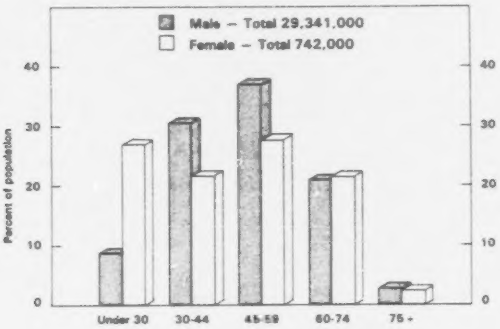


Fiscal year 1981 witnessed a drop in the size of the total veteran population for the first time in 16 years. Despite this, a net influx of 29,000 new female veterans was posted during this 12-month period. While the number of ex-servicemembers as a whole is expected to gradually fall in the years to come, the subgroup of women should continue to rise.

Age

The significant upturn in the number of female veterans over the last few years has brought with it a concomitant reduction in the median age of these women. The vast bulk of new entrants to the female veteran population are quite young, and this has led to a decline in the median age from 50.5 years as of September 30, 1977, to 46.2 years at the close of FY 1981. This stands in marked contrast to the advance in age observed in the male veteran population for which the median age has grown steadily from 45.1 years on June 30, 1970, to 50.3 years on September 30, 1981. Since the size of the male veteran population has recently begun to decline, this aging process should gain momentum in the coming years. The median age of female veterans exceeded that of their male counterparts each year until 1979, after which their relative age pattern has been reversed. The age structures of these two groups is expected to become more and more divergent during the next few years.

Chart 2. Estimated Male and Female Veteran Populations, By Age, September 30, 1981



Closer examination of the age distributions of male and female veterans illustrates some of the concepts outlined above. Whereas 27 percent of all women were under 30 years of age at the end of FY 1981, the comparable proportion was only 9 percent among men. This is vastly different from the situation existing in 1970 when a slightly greater share of male than of female veterans fell into this age group (16 percent vs. 14 percent, respectively).

Period of Military Service

Veteran survivors of World War II accounted for nearly two of every five females in the veteran population on September 30, 1981. Women who served in the Vietnam era only, constituted 27 percent, those whose only participation was in the Korean conflict comprised 10 percent, and World War I veterans made up 1 percent of the total. About one of every four women in the living veteran population as of the end of FY 1981 had served during peacetime periods only.

The distribution of female veterans by period of military service was fairly similar to that of males at the end of FY 1981. The major difference, and the one which largely explains the variance in the overall age structures of these two subgroups, is that a much greater proportion of women (17 percent) than of men (4 percent) had served in the armed forces during the post-Vietnam era only. Since veterans from this period of service are nearly all comparatively young, the female veteran population should continue to "grow younger" as sizeable numbers of post-Vietnam era participants are added to the population after separation from the armed forces.

EXPECTATIONS FOR THE FUTURE

What can be expected in the near future with regard to the number of female veterans in civil life? Will the marked increases experienced in the last five years continue? The answers to questions such as these may be partially addressed through an inspection of the counts of women on active duty in the armed forces, for it is from this pool that new entrants to the veteran population are drawn.

A total of 185,000 women were included in the active duty military personnel on September 30, 1981. This sum represented an increase of 65 percent over the number reported five years earlier. Women comprised 9 percent of all active duty military personnel near the end of FY 1981, a share which has been rising consistently since 1970. During the 1976-1981 period, the overall number of persons on active duty remained relatively constant at just under 2.1 million. While the count of active duty males may rise slightly during the next few years in the wake of our nation's anticipated military buildup, the number of women in the armed forces will very likely continue to grow by significant numbers. Should this trend persist, the female veteran population will maintain a course of steady growth since the pool of eligible entrants will be increasing. As the estimated count of female veterans rises in the years to come, an increasingly vital aspect of the VA's mission will be the special consideration given to the problems of this group of former military personnel with respect to the administration of various types of veteran programs, such as medical care, counselling, loan guaranty, and education.

Table 1. Estimated Veteran Population, By Sex, Fiscal Year 1970-1981
(in thousands)

End of fiscal year	Both Sexes	Male	Female
1970	27,647	27,132	515
1971	28,288	27,762	526
1972	28,804	28,267	537
1973	29,073	28,531	542
1974	29,265	28,714	551
1975	29,459	28,897	562
1976	29,607	29,030	577
1976-TQ	29,665	29,078	587
1977	29,844	29,224	620
1978	29,984	29,335	649
1979	30,072	29,393	679
1980	30,118	29,405	713
1981	30,083	29,341	742

SOURCE: Veterans Administration, Office of Reports and Statistics, Research Division, February 1982.

Table 2. Active Duty Military Personnel, By Sex, Fiscal Year
1970-1981
(in thousands)

End of fiscal year	Both Sexes	Male	Female
1970	3,066	3,025	41
1971	2,715	2,672	43
1972	2,323	2,278	45
1973	2,253	2,198	55
1974	2,162	2,087	75
1975	2,128	2,031	97
1976	2,082	1,973	109
1976-TQ	2,084	1,972	112
1977	2,075	1,956	119
1978	2,062	1,928	134
1979	2,027	1,876	151
1980	2,051	1,880	171
1981	2,083	1,898	185

SOURCE: Department of Defense, Directorate for Information Operations and Reports, *Selected Manpower Statistics.*

This series of statistical publications is designed to acquaint interested readers with some of the major findings associated with the divergent research efforts on veteran-related matters that are being addressed within the Veterans Administration's Office of Reports and Statistics. To obtain copies of this report, contact the author:

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Veterans
Administration

Women Veterans
Use of Educational Benefits Under the GI Bill

Series W-81-1

September 1981

Office of Reports and Statistics

WOMEN VETERANS
USE OF EDUCATIONAL BENEFITS UNDER THE GI BILL

Report W-81-1

by

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Statistician, Statistical Review & Analysis Division

Office of Reports & Statistics
Veterans Administration

September 1981

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PREFACE

This is the first of a series of studies relating to use of the various veterans benefits by women veterans. Historically very little data have been available because there were relatively so few women veterans to use the benefits. With the American public now more conscious of the contributions of women, a great level of interest has been generated on what women have done – or not done in the system. These papers will not attempt to resolve inadequacies as they may have existed; however, they may provide some basis for planning for the expected increased demand by ex-servicewomen.

Robert H. Feitz was the analyst and author of this study and report. James Lynch provided considerable data processing support. Jeanette Williams and Janet Somers provided the typing. Deborah Kilmade helped to compile some of the tables and Mark Russell provided assistance with some of the population statistics. Michael L. Facine was involved in the original conception of the studies and provided consultation and supervision.

ROBERT W. SCHULTZ
Assistant Deputy Administrator for
Reports and Statistics

EXECUTIVE SUMMARY

This report looks at the usage of GI bill benefits by women veterans of the post-Korean and Vietnam eras. Their usage patterns are compared in most instances with those of male veterans. Though the usage patterns of females and males are the same in certain areas, enough differences exist to warrant further studies. Future studies would probably be based upon data obtained from a survey of female veterans.

The female veterans as of September 30, 1980 had trained at a slightly lower rate than male veterans under the chapter 34 GI bill. Recent increases in the percentages of women veterans among new trainees and the fact that women veterans enter training later than male veterans should help to decrease this difference.

Female veterans are eligible for entitlement to training and earn about as much entitlement as male veterans. Overall, they use as much of their entitlement as male veterans but use less of it than males when training in college or in on-job training.

Female veterans come into the service more highly educated and are therefore more likely to have last trained at college level and less likely to have last trained in "on-job training" and "training by correspondence" than male veterans. They are also more likely to train full time vs. part time than male veterans and more likely to train in public vs. private institutions.

Certain geographic patterns are evident in examining the state location of last training for female veterans. Patterns of public vs. private training can be related to the availability of these institutions within each state. The percentage of female trainees within a state appears to be unrelated to the percentage of the female veteran population within a state.

Since this report covers data only from VA records, it tells nothing about female veterans who did not use their educational benefits, about female veterans' satisfaction with their benefits, nor about the applicability of these benefits to their civilian lives. If these types of information are important, it will be necessary to conduct a survey of female veterans.

PROGRAM DEFINITIONS

Terms used in this study to identify groups of beneficiaries are defined as follows:

Veterans and Service Personnel: Throughout this study the term "eligible veteran" refers to any civilian whose active military service exceeds 180 days and whose discharge or release from such service was under conditions other than dishonorable and who otherwise meet the eligibility criteria for VA educational assistance as prescribed by law. The term "service personnel" refers to military personnel on active duty as of a given date and in a first or continuous enlistment which exceeds 180 days, and is meant to include certain veterans reenlisted and on active duty as of that date, and who otherwise meet the eligibility criteria for VA educational assistance as prescribed by law.

Post-Korean Conflict: Refers to veterans who served after January 31, 1955, including those who served during the Vietnam era through December 31, 1976.

Peacetime Post-Korean Conflict: Refers to those veterans who served after January 31, 1955, but not after August 4, 1964.

Vietnam Era: Refers to veterans and service personnel who served on or after August 5, 1964. While the Vietnam era was ended by Presidential Proclamation as of May 7, 1975, the proclamation did not affect entitlement of chapter 34 benefits for those in service on May 7, 1975, or for those who entered active duty service prior to January 1, 1977. Similarly, the proclamation in no way affects chapter 31 or chapter 35 entitlement.

Post-Vietnam Era: This refers to all persons with service beginning on or after January 1, 1977. While the Vietnam era was ended by proclamation of the President on May 7, 1975, all persons who entered service subsequent to that date continued to have the same eligibility for educational benefits as any other post-Korean conflict veteran. With the passage of Public Law 94-502, eligibility criteria changed for persons who entered on active duty after December 31, 1976 (with a few exceptions).

The Current GI Bill (chapter 34) became effective June 1, 1966. It was enacted by the Congress to provide educational or vocational opportunities to veterans whose education plans may have been impeded by service in the Armed Forces after January 31, 1955. Also, these opportunities were made available to service personnel on active duty who had completed 181 or more days of service. Persons who completed 18 or more months of active duty in the Armed Forces were eligible for up to the equivalent of 45 months of full-time schooling or on-job training.

WOMEN VETERANS
USE OF EDUCATIONAL BENEFITS UNDER THE GI BILL

I. INTRODUCTION

This is the first in a series of reports on the historical patterns of veterans' benefits usage by female veterans. This report will address the usage of Veterans Educational Assistance (chapter 34, title 38, United States Code), commonly referred to as the post-Korean GI bill. The report will compare the patterns of educational usage between male and female veterans. Covered are sections on type of training, use of available entitlement, entry into training, type of institution, and an extensive section on location of training.

Future reports in the series will cover such subjects as hospital discharges, and compensation and pension characteristics of female veterans.

II. BACKGROUND

Today the U.S. has more women – and a greater percentage of women – serving in the military than any other country according to a report by *Newsweek* magazine.[1] Approximately 8 percent of the current total military strength of the U.S. are women, and the figure may reach 12 percent by 1985. These figures represent a dramatic increase since 1973 – the beginning of the all-volunteer Army. With nearly 95 percent of current Military Operational Specialties (MOS) open to women and the concept of women in combat positions still being debated, women are becoming an integral part of the military. With the possibility of an eventual draft which could include women, the potential for the military to have a large percentage of women is very real. Obviously the makeup of the military today predicts the makeup of the veteran population tomorrow. Therefore, it is important to study the potential impact of an increasing percentage of women veterans on VA programs.

As of September 1980, the 713,000[2] women veterans made up about 2.4 percent of the total veteran population. This is slightly higher than the 2.3 percent for veterans of the Vietnam era (with no service in the Korean conflict) and for World War II. Women make up only 1.6 percent of the Korean conflict veteran population but nearly 10 percent of the post-Vietnam era (PVE) veteran population. This latter figure reflects the large influx of women into the military with the advent of the all volunteer Army.

For veterans under 20 years of age (as of September 1980), 19 percent were women. Table 1 shows the percentages of women veterans in the total veteran population for other age groups.

TABLE 1
PERCENT OF WOMEN VETERANS IN TOTAL VETERAN POPULATION AS OF SEPTEMBER 30, 1980 BY AGE

Age Group	All Ages	Under 20	20-24	25-29	30-39	40-49	50-64	Over 65
Total veteran population (Thousands)	30,118	58	1,024	1,925	6,727	5,510	11,863	3,011
Percent women	2.4	19.0	7.5	5.0	1.6	1.5	2.2	2.5

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[1] *"Women in the Military", Newsweek, February 18, 1980, page 35.*

[2] *Veterans Administration, Office of Controller, Selected Characteristics of Female Veterans September 30, 1980 (January 7, 1981)*

BEST COPY AVAILABLE

The standards for recruiting women have traditionally been higher than those for recruiting men. The average woman recruit, therefore, is usually older and better educated than her male counterpart. This is reflected in the statistics on educational attainment at time of separation. Appendix Table 1 shows the educational attainment of Vietnam era veterans at the time they separated from the service. It compares percentages for all[3] veterans versus females for each year of separation from 1965 through 1979. Over 19 percent of the total veterans but less than two percent of the female veterans, were not high school graduates when they separated from service. The percentage of those who were college graduates were nearly identical for the total and for female separatees but female separatees had a slightly higher percentage with one or more years of college (16 percent versus 13 percent). Three of four female separatees fell into the high school graduate group (with less than one year of college) while only 60 percent of the total were in this group.

The level of education at time of separation influences usages of GI Bill educational benefits (see Survey of Veterans I and II)[4] with less educated veterans less likely to take advantage of the opportunities for training than the more educated veterans.

Since women veterans are more highly educated at separation than other veterans, they might be expected to train at higher rates than male veterans—everything else being equal. Of the total veterans who had ever used the post-Korean GI bill as of September 1980, 2.3 percent were women. This is slightly lower than the 2.5 percent of women in the total post-Korean population eligible for the post-Korean GI bill. Thus women veterans have used their educational opportunities at slightly lower rates than male veterans through the post-Korean period. A more detailed look at women veterans usage of GI bill benefits follows in Section III. Section IV will contain an analysis by state of training. Section V will draw conclusions and make recommendations for future studies. Most of the data for Section III and all of the data for Section IV are derived from special tabulations on an extract of the Veterans Administration Education Master Record taken as of September 1978.

III. FEMALE VETERANS' USAGE OF GI BILL BENEFITS

Participation in Training: In the introduction it was stated that women veterans appeared to be using their educational benefits at slightly lower rates than all veterans as of September 1980. Figure 1 illustrates that the percentage of women veterans who had ever trained under chapter 34 has consistently lagged behind the percentage of women veterans eligible for chapter 34 benefits. The gap narrowed somewhat in fiscal year 1980. A comparison of the percentage of female veterans among new entrants into training and the percentage of female veterans among separatees from the service who are eligible for chapter 34 benefits (see Figure 2) shows that female veterans as a percentage of new entrants surpassed their percentage among separatees in fiscal year 1978. The gap has continued to widen in fiscal years 1979 and 1980. This indicates that the percentage of veterans ever trained who are women may continue to increase relative to the percentage of women veterans in the eligible veteran population.

Though female veterans may yet reach parity, in terms of having the same percentage using the GI bill as male veterans, the question still arises as to why females have not up to now used their GI bill benefits at the same rate. As mentioned in the introduction it might have been expected that women would use the benefits more often since they come into the service with higher levels of education. Two possible reasons for non-usage are lack of motivation and lack of opportunity. Lack of motivation would include such reasons as a feeling that training was not needed or simply a preference to work or raise a family. Lack of opportunity could be family obligations, lack of money, or not being qualified. (These are possiblities that were mentioned by male veterans on the 1979 National Survey of Veterans). Except for the latter reason, these are reasons which cannot be discovered from available data and would require a survey administered to female veterans.

Another possible reason for the apparent lower rate of usage by female veterans may simply be that they enter training later after separation than male veterans and have not yet caught up. Some women separate from service because of pregnancy. These women would most likely delay entry into training.

Time of Entrance into Training: Data contained in a one-time tabulation taken from the Education Master Record as of September 1978 indicate that women do tend to enter training later than men. For all post-Korean veterans who had terminated training between August 5, 1964 and September 1978 about 50 percent had first entered training before separation from service or during their first year after separation. However, only about 42 percent of female veterans had entered

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[3] *Female veterans are compared to all veterans because of the nature of the data. Since women are contained in the veteran total, any differences between female and total imply even greater differences between male and female.*

[4] *Veterans Administration, Office of Controller: National Survey of Veterans (January 1980) and 1979 National Survey of Veterans (December 1980).*

FIGURE 1

Percent of Women Among Chapter 34 Veterans Ever Trained and Among Chapter 34 Eligible[1] Veteran Population

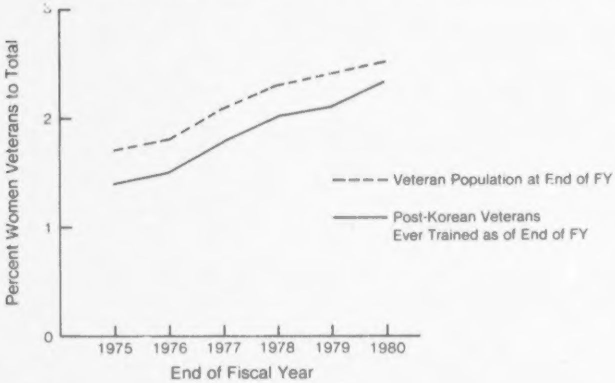
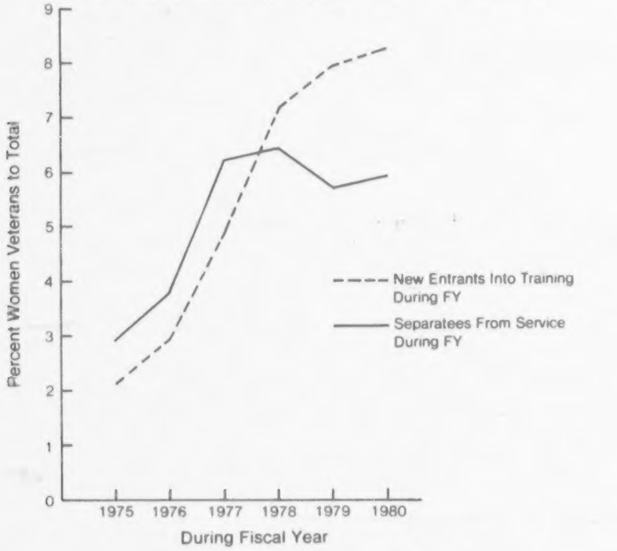


FIGURE 2

Percent of Women Among New Entrants Into Chapter 34 Training and Chapter 34 Eligible Separatees[2] From Service



[1] Service Between Korea and Vietnam Era, and Post Vietnam Entered Service Before 1/1/77

[2] Entered Service Before 1/1/77

training during this time period. The median time between separation from service and initial training for women veterans is about one year and five months versus only one year for veterans in general. Table 2 gives the median times for each of the major types of training. Except for training by correspondence, women enter training later than male veterans. In each case the data represent the most recent training used.

TABLE 2
MEDIAN TIME[1] BETWEEN SEPARATION FROM SERVICE[2] AND ORIGINAL ENTRY INTO TRAINING BY LAST TYPE OF TRAINING
(Months)

Type of Training	All Veterans	Female Veterans
Institutions of Higher Learning (IHL)	11	16
Other Residence Training	16	19
On-Job Training	12	17
Training by Correspondence (all levels)	27	26

[1] *The median time was calculated based upon aggregated data rather than from individual data and therefore are not highly accurate and should be used for comparative purposes only rather than absolute values. Medians were used because of the inherent skewness of the distribution.*

[2] *Terminated veterans separated between August 1964 and September 1978.*

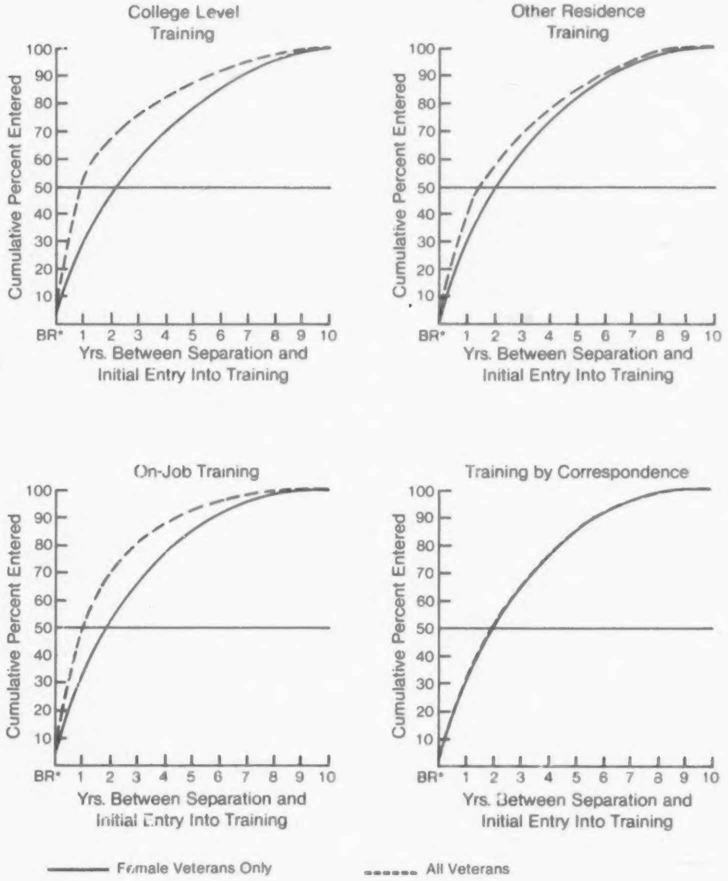
NOTE: A set of detailed tables showing the distribution of trainees (total and female) by years between separation and initial entry into training by type of training are given in Appendix Tables 2 through 6.

Figure 3 illustrates the same phenomenon for veterans separating from service between 1966 and 1974. By using this time period, those who separated from 1955 through 1965 but could not train until 1966 when the GI bill was passed are eliminated from consideration. They would bias the data since they were forced to delay entry into training by as much as 11 years.

It also includes only those who had at least four years in which to begin their training after their release from active duty. The higher, dotted line on the graph for "all veterans" shows they entered training earlier than female veterans. The largest differences are for training in college and on-job training. For training by correspondence the entry times are virtually identical. The same conclusion holds for those veterans who were in training as of September 1978 and who separated from service during fiscal years 1975 and 1976 – two of the years in which female separations began to increase beyond the two percent level. Obviously the median time between separation and initial entry into training is less for those separating in 1975 as compared to those separating in 1974; but for both years, female veterans entered training later than male veterans for each type of training.

FIGURE 3

Distribution[1] of Years Between Separation and
Initial Entry Into Training for Post-Korean Veterans Separated Between 1966-1974
(Not in Training as of Sept. 1978)
Last Type of Training



College Level Training

Other Residence Training

On-Job Training

Training by Correspondence

* Before Release From Active Duty

[1] Since females are included in data for "All Veterans," differences between male veterans and female veterans would actually be greater than differences appearing here.

TABLE 3
MEDIAN MONTHS[1] BETWEEN SEPARATION FROM SERVICE AND ORIGINAL ENTRY INTO TRAINING BY LAST TYPE OF TRAINING FOR SEPARATEES IN FISCAL YEARS 1975 AND 1976 WHO WERE IN TRAINING AS OF SEPTEMBER 1978
(Months)

		Type of Training			
Separated 7/1/74 - 6/30/75	TOTAL	Institutes of Higher Learning	Other Residence Schools	On-Job Training	Training by Correspondence
All Veterans	7.4	7.0	9.0	8.6	11.5
Female Veterans Only	14.5	13.5	24.0	19.5	20.0
Separated 7/1/75 - 6/30/76					
All Veterans	5.9	5.7	6.7	6.4	8.5
Female Veterans Only	10.0	10.0	15.0	9.0	15.0

[1] *See footnote 1 to Table 2.*

From this data it is impossible to determine *why* female veterans enter training later than male veterans. Such a determination would have to come from an actual survey of women veterans (see Section V) in which they were asked why they delayed entry into training. One possibility, previously mentioned, is that for those who are married the responsibilities of being a wife or a mother delay their entry.

Percent of Entitlement Used: It might be expected that an earlier start into training would be more likely to result in a greater usage of available entitlement since there is a longer time frame in which to use it. If this were the case, females, who tend to start later, would be likely to use less of their available entitlement than veterans in general. This is borne out by the fact that for all veterans the usage of entitlement is greatest for those entering training the first year after release from active duty and drops for each year of delay in beginning training. As indicated in Table 4 this is not the case for female veterans who tend to use a greater percentage of their entitlement the later they enter training—up to 7 to 8 years after separation from service. Thus, though total veterans have a higher usage rate than females for those entering training the first year after separation, females have higher usage rates for all later entering periods. Because of the high percentages of total veterans entering during the first year, the overall median percentage usage of entitlement is about the same for female veterans as it is for all veterans.

TABLE 4
MEDIAN PERCENTAGE [1] [2] OF ENTITLEMENT USED BY YEARS BETWEEN SEPARATION[3] AND ORIGINAL ENTRY INTO TRAINING FOR VETERANS SEPARATED BETWEEN AUGUST 1964 AND SEPTEMBER 1978 AND IN A TERMINATED TRAINING STATUS

Years Between Separation and Original Entry	All Veterans	Female Veterans
Before Release	28.5	28.7
0-1 years after RAD[4]	47.7	32.3
1-2 years after RAD	32.6	33.7
2-3 years after RAD	24.9	36.6
3-5 years after RAD	22.9	39.1
5-7 years after RAD	21.5	40.9
7-8 years after RAD	21.4	40.1
8-9 years after RAD	20.3	32.3
9 or more	16.4	20.8
TOTAL	33.4	34.1

[1] *The median is based on data aggregated into 25 percent groupings and are rough estimates only which should be used only for comparative purposes and not as absolute figures. The aggregated frequency distributions for the data are contained in Table 6.*

[2] *A base of 36 months was used for all percentages since veterans separated prior to October 1, 1976, only had a maximum of 36 months to earn. Therefore, the 100 percent category includes those with more than 36 months of entitlement who used at least 36 months of entitlement.*

[3] *See footnote 2 for Table 2.*

[4] *RAD – Release from Active Duty*

The same general pattern of usage rates by years between separation and initial entry into training holds for each type of training (see Appendix Tables 2 through 5). As indicated in Table 5, females tend to use less of their entitlement than male veterans when training in institutions of higher learning or on-job and more when training in other residence schools.

TABLE 5
MEDIAN PERCENTAGE[1] OF ENTITLEMENT USED BY LAST TYPE OF TRAINING

Type of Training	All Veterans[2]	Female Veterans Only[2]
Institutions of Higher Learning (IHL)	46.3	39.9
Other Residence Schools	19.4	26.3
On-Job Training	64.9	50.0
Training by Correspondence	13.4	13.0
TOTAL	33.4	34.1

[1] *See footnotes to Table 4.*

[2] *See footnote 2 to Table 2.*

Entitlement Available: Though females appear to use as much of their available entitlement as males, the question remains whether they had as much entitlement to use. Since all of the data on percent entitlement used is based on the number of months of entitlement earned by each individual, there is one measure than can shed some light on this question – the percentage of veterans using two months or less of training. If females had less entitlement on the average than males then they might be expected to have proportionately higher percentages in this two months or less category (often referred to as "walkaways"). That this is not true is revealed by Table 6 which shows female veterans having a lower percentage of walkaways overall and for other residence school training.

TABLE 6
VETERANS[1] USING TWO MONTHS OR LESS OF ENTITLEMENT[2] BY TYPE OF TRAINING LAST USED

Type of Training	All Veterans	Female Veterans Only	
	Percent	Number	Percent
Institutions of higher learning (IHL)	9.1	56,000	11.7
Other residence schools	34.4	11,000	18.0
On-job training	1.8	1,000	2.9
Training by Correspondence (all levels)	87.1	4,000	92.9
TOTAL	22.5	72,000	17.1

[1] *Terminated veterans separated between August 1964 and September 1978.*

[2] *For distributions by years between separation and initial entry into training see Appendix Tables 2 through 6.*

A more direct measure of entitlement earned can be obtained by observing length of service for males versus females.

TABLE 7
PERCENT OF VETERANS WITH LESS THAN 180 DAYS SERVICE BY YEAR OF ENTRY INTO SERVICE

Year of Entry	Males	Females
1973	8.7	10.9
1974	13.4	11.5
1975	13.7	11.7
1976	14.7	13.8
1977	14.0	12.9
TOTAL	12.8	12.2

Table 7 shows that in recent years female veterans have had a slightly lower percentage than males of those with less than 180 days of service (those not eligible for chapter 34 benefits).

By looking at the percentage of those who were eligible for chapter 34 benefits who would have earned maximum entitlement (served 18 months or more), it is evident that women veterans have earned maximum eligibility at a slightly lower rate than male veterans (Table 8.)

TABLE 8
PERCENT OF VETERANS AND/OR SERVICE PERSONNEL WHO HAVE EARNED MAXIMUM ENTITLEMENT BY YEAR OF ENTRY INTO SERVICE

Year of Entry	Males	Females
1973	88.2	83.9
1974	86.8	85.2
1975	86.8	86.4
1976	88.1	86.6
TOTAL	87.5	85.7

Based on all the data, it appears that women veterans earned about as much eligibility for chapter 34 benefits as men. Therefore, this is probably not a factor in studying the differences in usage patterns betwen males and females. Some questions remain which cannot be answered by the available data: Why do females exhibit different usage patterns from male veterans? What circumstances are unique to them that create these patterns? Since they start off later would they use more of their entitlement if they had more than 10 years in which to use it?

Type of Training Used: In addition to differences[5] between male and female veterans in time of entry into training and usage of available entitlement there are differences in the types of training used. Table 9 below shows the percentage of total trainees for all veterans and for female veterans only who last trained in various types of training for different periods of separation from service. All of these veterans were in a terminated status (not currently in training) as of September 1978. This table shows that, for each period, female veterans had a higher percentage using training in college and a lower percentage in on-job training and training by correspondence. In the most recent period (1974-1978), female veterans also had a much lower percentage training in other residence schools. Also shown is the trend towards "college training" and away from "training by correspondence" for all veterans and for female veterans only.

Training Time: Other differences in usage of educational benefits between males and females are exhibited in their choice of training time. Appendix Table 7 shows the numbers and percentages of post-Korean GI Bill trainees ever trained (as of 1978) by type of training, training time (full or part time), type of institution (private or public) and sex. The table shows that female veterans last trained at a full-time rate nearly 61 percent of the time versus only 54 percent for males. Moreover, females were more likely to train full-time regardless of type of training. By training full-time more often than male veterans, female veterans would use up their entitlement at a faster rate. This may have been a necessity due to their generally later training start or it may reflect greater opportunity than for male veterans. Assuming that these women veterans were less likely to be employed than the male veterans (an assumption based on total male-female populations) then they would have had a greater opportunity for full-time training usually requiring attendance during normal working hours. Even so, such training would still have been difficult along with other responsibilities such as raising a family.

As is clear from this brief discussion, many questions remain about why women veterans chose full-time training at greater rates than men. Answers can only be hinted at without an actual survey of the motivations and actions of the women veterans themselves (see Section V).

TABLE 9
PERCENT OF POST KOREAN VETERANS EVER TRAINED BY PERIOD OF SEPARATION AND LAST TYPE OF TRAINING

Type of Training	Type of Veteran	Number	All Periods	1964-1966	1966-1974	1974-1978
Institutes of Higher Learning	Female Only	56,386	78.0	69.7	76.4	83.7
	All Veterans	2,753,881	61.2	54.5	60.9	69.6
Other Residence Training	Female Only	11,020	15.2	18.3	15.3	14.1
	All Veterans	774,132	17.2	17.4	16.4	22.1
On-Job Training	Female Only	793	1.1	.9	1.2	.9
	All Veterans	411,243	9.1	7.7	9.9	5.3
Training by Correspondence	Female Only	4,117	5.7	11.1	7.1	1.3
	All Veterans	559,131	12.4	20.4	12.8	3.0
All Training	Female Only	72,316	100.0	100.0	100.0	100.0
	All Veterans	4,498,387	100.0	100.0	100.0	100.0

Proprietary Status of Training Institute: Table 10 below shows the percentage of veterans last trained in public institutions for all persons ever trained under the post-Korean GI bill as of September 1978, by type of training and sex. It shows that female veterans had a higher percentage than male veterans of those who had last trained in public institutions with the exception of training in other residence schools.

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[5] *All differences mentioned would be statistically significant at .05 level of confidence if the two groups were from samples rather than being the entire population for each group.*

One possible reason for a greater male participation in other public residence schools is that males generally have a higher percentage with less than a high school education; therefore, they are more likely to take high school training. High schools are more apt to be public institutions than other types of residence training such as vocational/technical.

TABLE 10
PERCENT OF VETERANS EVER TRAINED WHO LAST TRAINED IN PUBLIC INSTITUTIONS

Type of Training	Male	Female
Total All Residence Schools[1]	73.1	75.3
Total College Level	77.8	81.9
Junior Colleges	91.0	93.3
Other Residence Schools	57.0	39.3

[1] *Excludes training by correspondence and on-job training.*

IV. ANALYSIS OF USAGE BY STATE

All of the data in this section are derived from the special extract of the Education Master Record as of September 1978. The tables are arranged by the nine Census Regions.

Figure 4 shows the percent of females to total veterans for those post-Korean veterans who had ever trained up to September 1978. (Appendix Table 8 shows actual percentages). The Middle Atlantic and East North Central (Great Lakes states) regions had the lowest percentage of female veterans in training. The Mountain and South Atlantic Regions generally had the highest percentages of female trainees. Percentages varied from a high of 4.8 percent for Alaska and Maryland to a low of only 1.4 percent for New York.

The percentage of female veterans in the total veteran population was examined for each state to see if this could explain the patterns of educational utilization found.

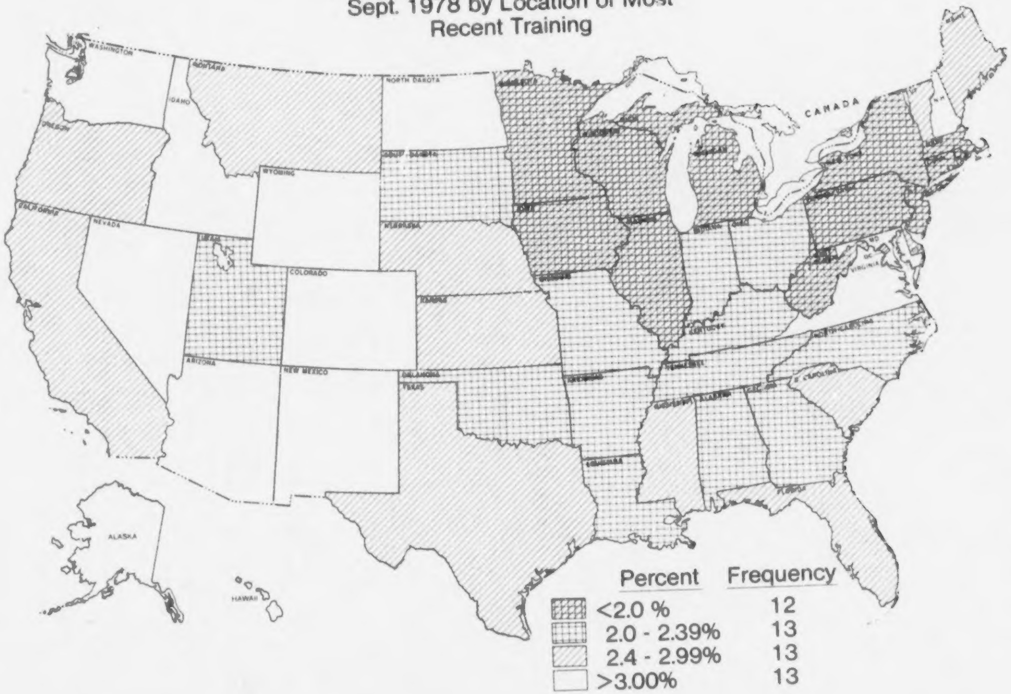
There was almost a zero correlation between the percentages of female veterans to total veteran population and percentages of female trainees to total trainees, i.e., one state having a high female population appeared to have no connection with it having or not having a high female trainee percentage. The conclusion from this is either that female participation is completely independent of female veteran density or that state estimates of female veterans are outdated. (When the 1980 Decennial Census data are made available, we will have a more accurate distribution of the female veteran population).

One possible explanation for the pattern of female educational usage is that it reflects a general migration of the population. The influx of female veterans is heavily weighted toward the latter years of the post-Korean periods (30 percent of female veterans who had terminated training as of September 1978 first entered training after 1974 compared to only 12 percent for male veterans). Therefore, female veterans would be more likely to have reflected recent population trends than male veterans. Indeed, by looking at figure 4, the pattern is for less female trainees in the Northeast and Great Lakes states (the snow belt) and more trainees in the West and Southwest and parts of the Southeast (the sun belt). This reflects the general migration shifts of the past 20 years.

One way of testing this theory is to break up the training data into periods of separation from service. Figures 5 and 6 show the percentage of female veterans to total who had terminated training as of September 1978 and who separated from service in 1964-1966 and 1974-1978, respectively. (Back-up tables are in Appendix Table 9). Though some obvious differences exist between the two charts they are very similar overall. A significant correlation of .6 exists between the two sets of percentages. In both charts (separated in time by nearly 10 years) the Middle Atlantic and East North Central regions both have lower percentages of female trainees. Thus, the same basic pattern has persisted over time and is not entirely due to veteran migration as speculated earlier.

FIGURE 4

Percent of Female Veteran Trainees Among Total Post-Korean Veterans Trained in Post-Korean G.I. Bill as of Sept. 1978 by Location of Most Recent Training


WASHINGTON
OREGON
CALIFORNIA
NEVADA
IDAHO
MONTANA
WYOMING
UTAH
COLORADO
ARIZONA
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
VIRGINIA
CANADA
ALASKA
HAWAII
Percent
Frequency
<2.0 %
12
2.0 - 2.39%
13
2.4 - 2.99%
13
>3.00%
13

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The data from 1974-1978 is very striking. There is a clear demarcation down the middle of the country with nearly the entire West experiencing higher female trainee percentages than the East except for most of the South Atlantic region (especially Maryland, Virginia and the District of Columbia).

To determine whether this pattern of female training among states is common to women trainees overall, the percentage of veterans training in college as of September 1978 who are women (see Appendix Table 10) was correlated with the percentage of women students among the fall 1977 enrollees in all institutions of higher education (Table 75 of Digest of Education Statistics 1979 - National Center for Education Statistics). The correlation was a rather low .25 (not significant at .01 level). It appears then that female veterans are unique in their usage of training benefits by location of training. Their location of training is independent of the population density by state and is only marginally related to the pattern of training by other non-veteran female trainees. Yet, it has been shown that the pattern is not strictly random since it has tended to persist over time. Thus, the question still remains as to why female veterans train at higher participation rates in some states as opposed to others. From the available data it is impossible to definitely determine the reason.

Several possible factors would probably end up in a model which would predict participation by state such as: average tuition cost, the mix of public versus private facilities, female unemployment statistics, marriage and divorce rates, average family size, types of employment available, urban versus rural mix, etc.

Training Time and Type of Institution: Appendix Table 8 has the percentage of post-Korean female veterans ever trained (as of September 1978) who trained full-time versus part-time. Overall, about 61 percent of this group last trained in a full-time basis. There were regional differences in the use of full-time versus part-time training. The New England region had the lowest percentage with only 54 percent while the East South Central region had the highest at 71 percent. Individual states ranged from 81 percent for West Virginia to a low of 34 percent for Maryland. Earlier it was stated that females were more likely to train full-time in non-degree-granting residence schools as opposed to training in institutions of higher learning. Therein lies one of the biggest factors in the pattern of full-time usage differences by states. There is a significant negative correlation of -.47 between the percentage of women training in college versus the percentage of women training full-time. This implies that states with higher percentages of women in college will likely have lower percentages of women training full-time. For example, Montana with one of the highest percentages of full-time trainees, has the lowest percentage of trainees in college (see Appendix Table 11). Maryland has the lowest percentage of full-time trainees and one of the highest percentages of college level trainees (94 percent). There are of course exceptions such as Utah and Wyoming which have both high rates of college training and full-time trainees, but in general the pattern holds. Obviously other factors are involved in determining the training time of female veterans in all states, especially states such as Utah and Wyoming.

Appendix Table 8 also shows the percentage of female veterans who last trained in public (versus privately supported) institutions. Overall, about 75 percent of women veterans trained in public institutions. There was considerable variation among the regions and states from a high of 80 percent for Mountain and Pacific regions to a low of 55 percent for New England and Middle Atlantic regions. Rhode Island was the lowest state with only 35 percent versus a high of 96 percent for Wyoming. Correlating these percentages with the percentages of public institutions of higher learning in the states revealed a high correlation of nearly .7. This not surprising result indicates that much of the variation in the pattern of public training can simply be explained by the availability of public institutions. An even higher relationship may have been found by correlating with the total percentage of public residence institutions rather than with just institutions of higher learning.

Tuition costs at the public versus private institutions within a state are probably also one of the determining factors.

FIGURE 5

Percent of Female Veteran Trainees Among Post-Korean Veterans Separated Between 1964-1966 and Not in Training as of Sept. 1978 by Location of Most Recent Training

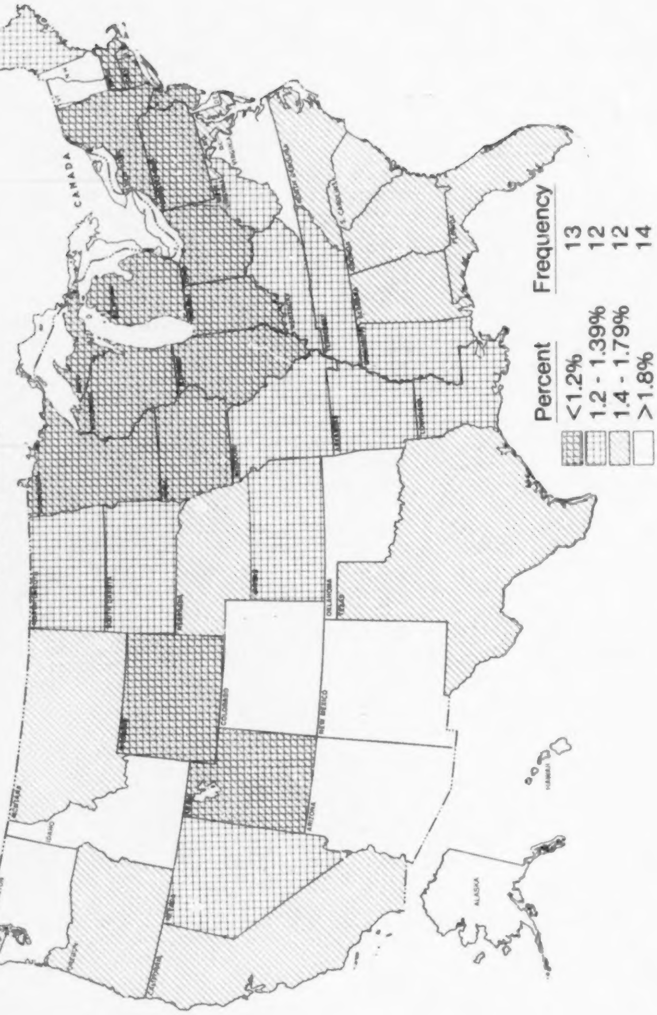
CANADA
Percent
Frequency
<1.2% 13
1.2 - 1.39% 12
1.4 - 1.79% 12
>1.8% 14

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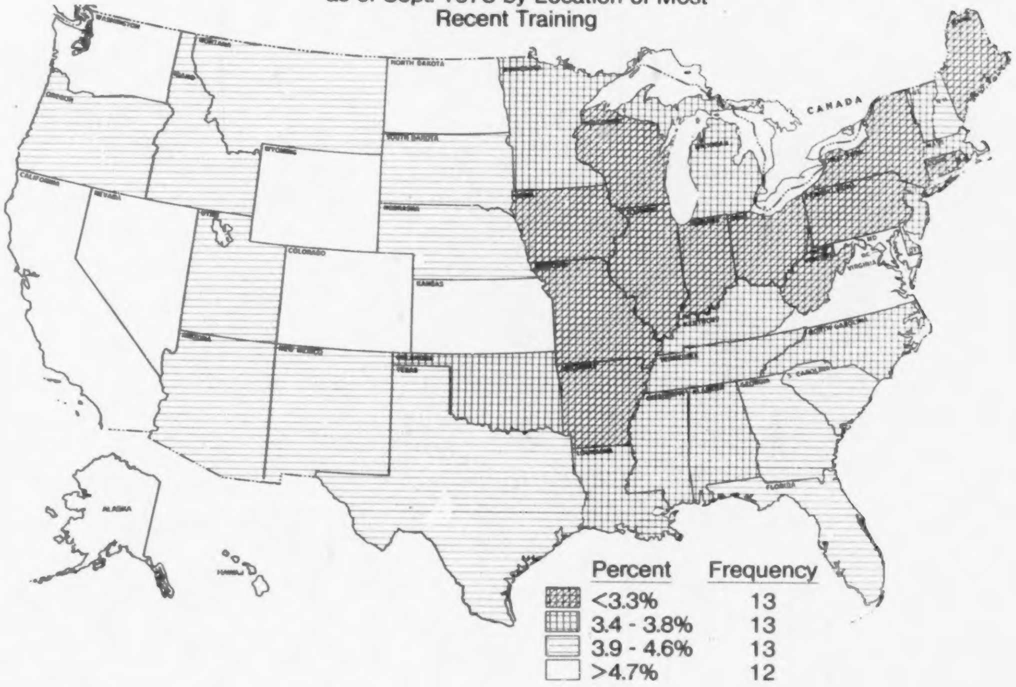
FIGURE 6

Percent of Female Veteran Trainees Among Post-Korean Veterans Separated Between 1974-1978 and Not in Training as of Sept. 1978 by Location of Most Recent Training


CANADA
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
COLORADO
NEW MEXICO
TEXAS
ALASKA
HAWAII
Percent
Frequency
▩ <3.3% 13
▦ 3.4 - 3.8% 13
▤ 3.9 - 4.6% 13
☐ >4.7% 12

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V. CONCLUSIONS

Women veterans come into the service with higher levels of education on the average than male veterans. They might be expected to use their educational benefits at a higher rate than male veterans, but in fact, have actually used their benefits at a slightly lower participation rate than males through fiscal year 1980. The current trend of new veterans indicates that the women veterans are catching up.

Partly because of their higher educational levels at entrance into the service, women veterans are less likely to need high school or remedial training and are more likely to train in institutions of higher learning than male veterans. Women veterans tend to begin their training later after separation than male veterans. In spite of this, they appear to use as much of their available entitlement as male veterans. Partly because of their late start, they are more likely than male veterans to train full-time in order to get the most use from their entitlement.

There are regional and state differences in the pattern of GI bill usage by female veterans. Women veterans make up a higher percentage of total veterans who are in training or have ever trained in the western half of the country and parts of the South Atlantic region than in the rest of the country. This pattern cannot be explained by female veteran population patterns.

The pattern of full-time training among female veterans across states is partly explained by their pattern of training in institutions of higher education. A pattern of training in public versus private institutions is highly related to the availability of each type of institution within a state.

Many questions were left unanswered and many were raised by the analysis of the existing data (much of which came from a one-time special pass through the Education Master Record as of September 1978). To provide complete answers for these questions would require the gathering of more complete data. Questions such as the following have gone unanswered: (1) why do female veterans go into training? or why not?; (2) why do they use the types of training they do?; (3) how do they decide when to begin training?; (4) why do they complete or not complete their training?; (5) why and how do female veterans differ in their use of benefits in different regions?; (6) how satisfied are they with VA educational benefits?; (7) how would they like the VA to change benefits to meet their unique needs?, etc. These questions deal with motivations, aspirations, satisfactions, etc. and cannot be answered by investigating current VA files. If these types of questions are important, then they can only be answered by acquiring data on female veterans from sources other than those currently available within the VA.

Appendix Table 1

EDUCATIONAL ATTAINMENT OF VIETNAM ERA [1] VETERANS AT TIME OF SEPARATION - FISCAL YEAR 1965 THROUGH FISCAL YEAR 1979

Fiscal Year	Number Separated (000's)		Percent of Separatees Female	Percentage Distribution							
				Less Than 12 Years School (Not H.S. Graduate)		Completed 12 Years School (H.S. Graduate)		1 to 3 Years of College (Some College)		4 or More Years College (College Graduate)	
	Total	Female		Total	Female	Total	Female	Total	Female	Total	Female
1965	456	8.3	1.82	28.5	2.7	55.1	67.6	10.0	21.6	6.4	8.1
1966	507	5.9	1.16	22.2	1.9	59.5	84.7	10.9	9.6	7.4	3.8
1967	533	7.4	1.39	23.5	5.8	59.8	63.4	10.3	21.2	6.4	9.6
1968	745	8.9	1.19	20.2	2.6	61.8	75.0	12.3	15.8	5.7	6.6
1969	[illegible]	12.4	1.32	18.2	0.9	60.4	77.0	14.7	12.4	6.7	9.7
1970	1,012	13.3	1.31	19.7	1.9	56.9	70.9	14.9	14.6	8.5	12.6
1971	975	18.2	[illegible]	18.7	0.6	55.6	74.1	15.9	8.6	9.8	16.7
1972	850	[illegible]	[illegible]	18.2	1.0	54.4	70.1	14.8	19.6	12.6	9.3
1973	594	[illegible]	[illegible]	16.7	1.2	58.3	72.9	13.6	11.8	11.4	14.1
1974	547	[illegible]	[illegible]	18.8	3.3	59.1	72.5	11.1	11.7	11.0	12.5
1975	523	[illegible]	[illegible]	21.1	2.8	59.8	72.4	10.7	14.5	8.4	10.3
1976	412	[illegible]	[illegible]	19.6	0.5	66.5	79.7	10.9	17.7	3.0	2.0
1977 [2]	503	[illegible]	6.96	15.0	0.3	70.1	79.5	11.4	18.1	3.5	2.1
1978	277	[illegible]	6.43	10.1	0.2	72.7	77.8	13.0	19.4	4.2	2.6
1979 [3]	196	9.6	4.90	6.6	0.2	71.9	74.5	15.4	21.7	6.1	3.6
TOTAL [3]	9,070	200.1	2.21	19.2	1.3	59.9	75.1	13.0	16.1	7.9	7.5

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[1] For female veterans this does not include those with service both in Korea and Vietnam.

[2] Includes Transition Quarter.

[3] Preliminary

Appendix Table 2

ENTITLEMENT USAGE BY TERMINATED POST-KOREAN VETERANS [1] -- AS OF SEPTEMBER 1978

WHOSE LAST TRAINING WAS IN INSTITUTIONS OF HIGHER LEARNING BY YEARS BETWEEN SEPARATION AND INITIAL ENTRY INTO TRAINING

	ALL VETERANS				FEMALE VETERANS ONLY			
Years Between Separation and Initial Entry Into Training	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used
Before Release	207,132	7.52	8.78	37.7	3,529	6.26	7.40	31.5
0-1 Years after RAD	1,300,274	54.74	6.23	57.8	21,281	44.00	12.65	37.2
1-2 Years after RAD	389,361	68.88	9.73	46.2	9,295	60.48	12.51	40.2
2-3 Years after RAD	221,616	76.92	11.09	41.5	5,292	69.87	11.94	44.7
3-5 Years after RAD	290,602	87.48	12.47	36.8	7,299	82.81	10.56	47.9
5-7 Years after RAD	191,010	94.41	14.25	32.4	5,012	91.70	9.70	49.7
7-8 Years after RAD	65,340	96.78	14.87	29.8	1,863	95.01	10.41	47.6
8-9 Years after RAD	46,223	98.46	15.98	24.4	1,517	97.70	10.35	34.3
9 or More Years after RAD	42,323	100.00	19.72	17.5	1,298	100.00	16.26	21.3
TOTAL	2,753,881		9.10	46.3	56,386		11.65	39.9

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[1] Those separated between August 1964 and September 1978 are included.

Appendix Table 3

ENTITLEMENT USAGE BY TERMINATED POST-KOREAN VETERANS 1/ -- AS OF SEPTEMBER 1978

WHOSE LAST TRAINING WAS IN OTHER RESIDENCE TRAINING BY YEARS BETWEEN SEPARATION AND INITIAL ENTRY INTO TRAINING

	ALL VETERANS				FEMALE VETERANS ONLY			
Years Between Separation and Initial Entry Into Training	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used
Before Release	59,836	7.73	40.29	17.3	453	4.11	19.65	21.1
0-1 Years after RAD	288,351	44.98	27.96	21.5	3,813	38.71	18.36	23.8
1-2 Years after RAD	118,343	60.26	32.24	19.8	2,105	57.81	18.48	26.5
2-3 Years after RAD	77,517	70.28	36.07	18.9	1,173	68.46	19.35	27.6
3-5 Years after RAD	106,621	84.05	38.85	18.4	1,601	82.99	18.18	30.3
5-7 Years after RAD	69,300	93.00	41.67	18.0	1,002	92.08	13.87	31.0
7-8 Years after RAD	22,643	95.93	43.07	18.0	369	95.43	15.99	28.8
8-9 Years after RAD	15,708	97.96	44.52	17.3	245	97.65	15.10	31.7
9 or More Years after RAD	15,813	100.00	52.93	15.2	259	100.00	18.53	21.6
TOTAL	774,132		34.39	19.4	11,020		17.96	26.3

1/ Those separated between August 1964 and September 1978 are included.

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Appendix Table 4

ENTITLEMENT USAGE BY TERMINATED POST-KOREAN VETERANS [1] -- AS OF SEPTEMBER 1978

WHOSE LAST TRAINING WAS IN ON-JOB TRAINING BY YEARS BETWEEN SEPARATION AND INITIAL ENTRY INTO TRAINING

	ALL VETERANS				FEMALE VETERANS ONLY			
Years Between Separation and Initial Entry Into Training	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used
Before Release	22,315	5.43	1.79	53.8	48	6.05	0.00	45.5
0-1 Years after RAD	183,176	49.97	1.45	69.4	291	42.75	3.09	47.7
1-2 Years after RAD	71,036	67.24	1.61	68.1	129	59.02	6.20	54.9
2-3 Years after RAD	45,793	78.38	1.77	65.7	107	72.51	2.80	57.1
3-5 Years after RAD	51,745	90.96	2.16	60.7	93	84.24	1.08	47.9
5-7 Years after RAD	23,620	96.70	2.58	55.0	61	91.93	1.64	50.6
7-8 Years after RAD	6,123	98.19	3.05	51.5	29	95.59	3.45	56.3
8-9 Years after RAD	3,937	99.15	3.30	45.7	17	97.73	0.00	56.3
9 or More Years after RAD	3,498	100.00	5.75	34.6	18	100.00	0.00	45.5
TOTAL	411,243		1.76	64.9	793		2.90	50.8

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[1] Those separated between August 1964 and September 1978 are included.

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Appendix Table 5

ENTITLEMENT USAGE BY TERMINATED POST-KOREAN VETERANS [1] -- AS OF SEPTEMBER 1978

WHOSE LAST TRAINING WAS IN CORRESPONDENCE BY YEARS BETWEEN SEPARATION AND INITIAL ENTRY INTO TRAINING

	ALL VETERANS				FEMALE VETERANS ONLY			
Years Between Separation and Initial Entry Into Training	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used
Before Release	19,760	3.53	81.94	13.6	119	2.89	89.08	13.4
0-1 Years after RAD	147,619	29.94	72.24	14.7	1,127	30.26	99.09	13.1
1-2 Years after RAD	93,537	46.66	86.15	13.4	747	48.41	93.04	13.0
2-3 Years after RAD	74,673	60.02	91.38	13.0	524	61.14	89.69	13.2
3-5 Years after RAD	110,758	79.83	94.74	12.8	764	79.69	93.59	12.9
5-7 Years after RAD	70,546	92.45	97.18	12.6	525	92.45	96.00	12.7
7-8 Years after RAD	20,150	96.05	98.07	12.6	155	96.21	97.42	12.6
8-9 Years after RAD	12,294	98.25	98.83	12.6	86	98.30	95.35	12.8
9 or More Years after RAD	9,794	100.00	99.32	12.5	70	100.00	100.00	12.5
TOTAL	559,131		87.06	13.4	4,117		92.23	13.0

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[1] Those separated between August 1964 and September 1978 are included.

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Appendix Table 6

ENTITLEMENT USAGE BY TERMINATED POST-KOREAN VETERANS [1] -- AS OF SEPTEMBER 1978

TOTAL BY YEARS BETWEEN SEPARATION AND INITIAL ENTRY INTO TRAINING

	ALL VETERANS				FEMALE VETERANS ONLY			
Years Between Separation and Initial Entry Into Training	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used	Total Trained	Cumulative Percentage	Percent Used Two Months or Less of Entitlement	Median Percentage Entitlement Used
Before Release	309,043	6.87	19.05	28.5	4,149	5.74	10.99	28.7
0-1 Years after RAD	1,919,420	49.54	14.11	47.7	26,512	42.40	16.62	32.3
1-2 Years after RAD	672,277	64.48	23.46	32.6	12,276	59.37	18.37	33.7
2-3 Years after RAD	419,599	73.81	28.98	24.9	7,096	69.19	18.77	36.6
3-5 Years after RAD	559,726	86.25	32.82	22.9	9,757	82.68	18.22	39.1
5-7 Years after RAD	354,476	94.13	35.34	21.5	6,600	91.81	17.12	40.9
7-8 Years after RAD	114,256	96.67	34.50	21.4	2,416	95.15	16.76	40.1
9-9 Years after RAD	78,162	98.41	34.11	20.3	1,865	97.73	14.80	32.3
9 or More Years after RAD	71,428	100.00	37.30	16.4	1,645	100.00	20.00	20.8
TOTAL	4,498,387		22.47	33.4	72,316		17.10	34.1

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[1] Those separated between August 1964 and September 1978 are included.

Appendix Table 7

TOTAL POST-KOREAN CONFLICT GI BILL TRAINEES EVER TRAINED IN RESIDENCE TRAINING

AS OF SEPTEMBER 1978

	TOTAL ALL SCHOOLS		TOTAL - IHL		JUNIOR COLLEGES		OTHER RESIDENCE SCHOOLS	
	Male	Female	Male	Female	Male	Female	Male	Female
GRAND TOTAL	5,357,542	131,684	4,149,433	111,228	1,893,187	55,297	1,208,109	20,456
Percent Full Time	54.34	60.91	51.99	58.55	44.19	56.58	62.43	73.78
Public - Total	3,918,020	99,179	3,228,939	91,131	1,722,771	51,577	689,081	8,048
Percent Full Time	53.49	59.40	51.06	58.39	41.96	55.50	64.84	70.89
Private - Total	1,439,260	32,494	920,236	20,086	170,416	3,720	519,024	12,408
Percent Full Time	56.67	65.50	55.22	59.23	66.69	71.64	59.23	75.66

Appendix Table 8

CURRENT OR LATEST LOCATION OF TRAINING FACILITY FOR WOMEN VETERANS LAST TRAINED IN INSTITUTIONS OF HIGHER LEARNING OR OTHER RESIDENCE SCHOOLS - EVER TRAINED AS OF SEPTEMBER 30, 1978

	Total Number of Women	Percent of Male & Female Total	Percent of Women Training Full Time	Percent of Women Training in Public Institutions
Connecticut	941	1.90	53.03	68.86
Maine	610	2.62	60.33	62.46
Massachusetts	2,393	1.75	52.74	52.78
New Hampshire	665	3.20	57.89	50.98
Rhode Island	506	1.65	41.50	34.98
Vermont	147	2.74	63.27	51.02
New England Region	5,262	1.98	53.53	54.79
New Jersey	1,647	1.58	59.44	75.41
New York	4,150	1.43	58.82	54.02
Pennsylvania	3,053	1.77	65.31	45.73
Middle Atlantic Region	8,850	1.56	61.18	55.16
Illinois	3,913	1.76	53.59	79.96
Indiana	1,902	2.09	59.20	72.50
Michigan	3,424	1.78	58.32	81.16
Ohio	3,712	2.02	65.01	70.07
Wisconsin	1,572	1.91	67.81	86.01
East North Central	14,523	1.88	59.90	77.39
Iowa	922	1.80	74.40	66.81
Kansas	1,326	2.58	66.44	77.68
Minnesota	1,615	1.78	77.52	77.59
Missouri	2,983	2.22	60.34	53.77
Nebraska	1,135	2.78	57.62	63.26
North Dakota	478	3.10	70.92	83.68
South Dakota	433	2.39	74.13	60.28
West North Central	8,892	2.21	66.72	66.15
Delaware	415	2.69	54.70	72.53
District of Columbia	1,374	2.76	50.73	22.71
Florida	6,576	2.81	61.89	79.73
Georgia	3,290	2.31	65.47	70.06
Maryland	5,624	4.80	33.87	92.67
North Carolina	3,185	2.14	72.18	81.60
South Carolina	2,115	2.53	69.69	78.63
Virginia	4,348	4.08	55.31	73.99
West Virginia	631	1.91	81.46	60.70
South Atlantic Region	27,558	2.96	57.13	77.06
Alabama	2,811	2.39	66.49	86.27
Kentucky	1,523	2.16	74.79	67.43
Mississippi	1,054	2.68	72.39	83.21
Tennessee	2,279	2.10	73.54	71.65
East South Central	7,667	2.28	71.04	77.76
Arkansas	1,108	2.29	76.35	78.61
Louisiana	1,734	2.23	73.82	77.57
Oklahoma	2,127	2.32	65.44	80.39
Texas	9,766	2.75	61.25	79.01
West South Central	14,735	2.57	64.47	79.01
Arizona	2,983	3.19	61.55	87.19
Colorado	3,473	3.24	63.86	78.03
Idaho	545	3.21	74.86	83.12
Montana	483	2.91	79.50	74.95
Nevada	680	3.31	54.85	81.76
New Mexico	1,135	3.30	71.28	74.19
Utah	835	2.18	70.06	70.90
Wyoming	266	3.55	71.80	95.86
Mountain Region	10,406	3.10	65.42	80.49
Alaska	488	4.84	46.93	80.33
California	23,930	2.72	55.98	81.02
Hawaii	1,460	3.23	53.84	58.63
Oregon	2,010	2.74	72.94	85.37
Washington	4,467	3.37	75.40	80.77
Pacific Region	32,355	2.84	59.48	80.23
U.S. Total	130,242	2.45	61.12	75.29
Other Total	1,442	0.86	42.23	77.81
GRAND TOTAL	131,684	2.40	60.91	75.32

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Appendix Table 9

CURRENT OR LATEST LOCATION OF TRAINING FACILITY
FOR WOMAN VETERANS HAVING TRAINED UNDER POST-KOREAN CONFLICT GI BILL
BUT NOT IN TRAINING AS OF SEPTEMBER 30, 1978

	Separated From Service 1964 - 1966			Separated From Service 1974 - 1978		
	Total Number of Women	Percent of Grand Total	Percent of Male & Female Total	Total Number of Women	Percent of Grand Total	Percent of Male & Female Total
Connecticut	[illegible]	1.80	1.38	124	0.58	3.17
Maine	[illegible]	0.47	1.93	95	0.43	3.04
Massachusetts	[illegible]	1.61	0.99	317	1.45	3.74
New Hampshire	24	0.35	2.51	79	0.36	3.87
Rhode Island	15	0.24	1.28	49	0.23	2.53
Vermont	14	0.21	1.90	26	0.11	4.31
New England Region	290	4.47	1.19	687	3.11	3.14
New Jersey	105	1.61	0.90	291	1.33	3.68
New York	250	3.80	0.81	714	3.26	3.57
Pennsylvania	147	3.21	0.95	471	2.15	3.02
Middle Atlantic Region	582	8.88	0.88	1,476	6.75	3.31
Illinois	196	2.98	0.91	574	2.64	3.14
Indiana	112	1.69	1.26	283	1.29	3.19
Michigan	206	3.13	1.39	574	2.62	3.42
Ohio	224	3.36	1.04	674	3.07	3.28
Wisconsin	[illegible]	1.14	0.94	229	1.04	3.03
East North Central	814	12.34	1.07	2,334	10.67	3.23
Iowa	52	0.79	1.52	150	0.68	3.99
Kansas	51	0.77	1.25	245	1.12	5.07
Minnesota	109	1.66	1.51	363	1.65	3.94
Missouri	180	2.74	1.23	315	1.51	3.37
Nebraska	41	0.62	1.12	158	0.72	3.35
North Dakota	16	0.24	1.30	91	0.42	5.07
South Dakota	27	0.41	1.57	74	0.34	4.08
West North Central	433	6.49	1.27	1,455	6.64	3.73
Delaware	32	0.49	2.17	66	0.30	3.43
District of Columbia	98	1.49	2.33	144	0.66	5.48
Florida	314	4.77	1.67	1,139	5.19	4.07
Georgia	159	2.41	1.47	607	2.77	4.53
Maryland	149	2.25	1.76	799	3.60	6.89
North Carolina	139	2.03	1.49	563	2.57	3.47
South Carolina	92	1.39	1.75	386	1.76	4.04
Virginia	172	2.59	2.31	875	3.99	6.06
West Virginia	42	0.63	1.29	100	0.46	2.55
South Atlantic Region	1,206	18.73	1.72	4,669	21.30	4.56
Alabama	117	1.78	1.54	498	2.27	3.88
Kentucky	73	1.10	1.26	274	1.25	3.85
Mississippi	34	0.51	1.29	216	0.99	3.88
Tennessee	124	1.87	1.35	450	2.05	3.64
East South Central	348	5.25	1.38	1,438	6.56	3.73
Arkansas	43	0.65	1.25	142	0.65	3.24
Louisiana	81	1.24	1.22	344	1.57	3.55
Oklahoma	132	1.99	2.00	304	1.39	3.41
Texas	461	6.96	1.77	1,774	8.09	4.51
West South Central	719	10.84	1.67	2,604	11.88	4.17
Arizona	129	1.95	1.43	451	2.06	4.63
Colorado	175	2.64	2.21	581	2.64	3.45
Idaho	37	0.56	2.31	90	0.41	4.07
Montana	24	0.36	1.43	99	0.45	4.57
Nevada	23	0.35	1.34	120	0.55	4.83
New Mexico	38	0.58	2.50	168	0.77	4.49
Utah	35	0.24	1.16	162	0.74	4.03
Wyoming	8	0.12	1.08	58	0.26	3.35
Mountain Region	493	7.44	1.80	1,728	7.88	4.77
Alaska	15	0.23	7.40	127	0.58	17.41
California	1,061	[illegible]	1.79	3,919	17.87	4.75
Hawaii	71	1.07	3.41	149	0.68	4.44
Oregon	100	1.51	1.54	390	1.78	4.61
Washington	241	3.79	2.13	861	3.93	5.87
Pacific Region	1,581	24.89	1.86	5,446	24.84	3.93
U.S. Total	[illegible]	99.47	1.42	21,837	99.60	4.18
Other Total	35	0.53	2.55	88	0.40	2.53
Grand Total	[illegible]	100.00	1.41	21,925	100.00	4.17

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Appendix Table 10

CURRENT OR LATEST LOCATION OF TRAINING FACILITY
FOR WOMEN VETERANS IN TRAINING IN INSTITUTIONS OF HIGHER EDUCATION
AS OF SEPTEMBER 30, 1978

	Number of Women Veterans	Percent of Grand Total	Percent of Male & Female Total
Connecticut	203	0.90	3.92
Maine	104	0.46	4.40
Massachusetts	349	1.55	2.97
New Hampshire	108	0.48	4.53
Rhode Island	74	0.33	2.49
Vermont	25	0.11	4.97
New England Region	863	3.82	3.43
New Jersey	283	1.25	3.33
New York	586	2.59	3.15
Pennsylvania	606	2.68	4.18
Middle Atlantic Region	1,475	6.53	3.55
Illinois	612	2.71	3.32
Indiana	310	1.37	3.63
Michigan	540	2.39	4.39
Ohio	618	2.74	4.87
Wisconsin	375	1.66	4.21
East North Central	2,455	10.87	4.03
Iowa	176	0.78	4.36
Kansas	279	1.24	4.82
Minnesota	231	1.02	4.66
Missouri	504	2.23	4.38
Nebraska	189	0.84	4.69
North Dakota	104	0.46	7.48
South Dakota	93	0.41	6.65
West North Central	1,576	6.98	4.76
Delaware	73	0.32	5.94
District of Columbia	132	0.58	5.02
Florida	1,203	5.33	5.66
Georgia	437	1.93	5.78
Maryland	500	2.21	5.76
North Carolina	668	2.96	5.05
South Carolina	492	2.18	4.79
Virginia	647	2.86	6.62
West Virginia	150	0.66	3.57
South Atlantic Region	4,302	19.05	5.46
Alabama	432	1.91	4.60
Kentucky	362	1.60	5.46
Mississippi	227	1.01	5.62
Tennessee	425	1.88	4.89
East South Central	1,446	6.40	5.03
Arkansas	234	1.04	5.19
Louisiana	330	1.46	5.57
Oklahoma	485	2.15	4.58
Texas	2,074	9.18	5.04
West South Central	3,123	13.83	5.03
Arizona	810	3.59	5.96
Colorado	503	2.23	5.62
Idaho	109	0.48	4.86
Montana	66	0.29	6.90
Nevada	116	0.51	4.86
New Mexico	221	0.98	5.45
Utah	163	0.72	4.54
Wyoming	64	0.28	6.86
Mountain Region	2,052	9.09	5.59
Alaska	31	0.14	12.11
California	3,760	16.65	5.56
Hawaii	195	0.86	4.93
Oregon	368	1.63	6.54
Washington	834	3.69	7.87
Pacific Region	5,188	22.97	5.89
U.S. Total	22,480	99.54	4.94
Other Total	104	0.46	1.67
GRAND TOTAL	22,584	100.00	4.89

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Appendix Table 11

CURRENT OR LATEST LOCATION OF TRAINING FACILITY
FOR WOMEN VETERANS LAST TRAINED IN INSTITUTIONS OF HIGHER LEARNING
(EVER TRAINED AS OF SEPTEMBER 30, 1978)

	Number of Women Veterans	Percent of Grand Total	Percent of Total Trainees Per State
Connecticut	811	0.73	86.18
Maine	519	0.47	85.08
Massachusetts	2,131	1.92	89.05
New Hampshire	596	0.54	89.62
Rhode Island	442	0.40	87.35
Vermont	130	0.12	88.44
New England Region	4,629	4.16	87.97
New Jersey	1,420	1.28	86.22
New York	3,559	3.20	85.76
Pennsylvania	2,436	2.19	79.79
Middle Atlantic Region	7,415	6.67	83.79
Illinois	3,601	3.24	92.03
Indiana	1,485	1.34	78.08
Michigan	3,089	2.78	90.22
Ohio	3,085	2.77	83.11
Wisconsin	1,315	1.18	83.65
East North Central	12,575	11.31	86.59
Iowa	699	0.63	75.81
Kansas	1,038	0.93	78.28
Minnesota	1,081	0.97	66.93
Missouri	2,540	2.28	85.15
Nebraska	900	0.81	79.30
North Dakota	363	0.33	75.94
South Dakota	369	0.33	85.22
West North Central	6,990	6.28	78.61
Delaware	378	0.34	91.08
District of Columbia	1,144	1.03	83.26
Florida	5,553	4.99	84.44
Georgia	2,256	2.03	68.57
Maryland	5,279	4.75	93.87
North Carolina	2,796	2.51	87.79
South Carolina	1,729	1.55	81.75
Virginia	3,482	3.13	80.08
West Virginia	505	0.45	80.03
South Atlantic Region	23,122	20.78	83.90
Alabama	2,192	1.97	77.98
Kentucky	1,299	1.17	85.29
Mississippi	850	0.76	80.65
Tennessee	1,900	1.71	83.37
East South Central	6,241	5.61	81.40
Arkansas	828	0.74	74.73
Louisiana	1,189	1.07	68.57
Oklahoma	1,747	1.57	82.13
Texas	8,411	7.56	86.13
West South Central	12,175	10.95	82.63
Arizona	2,688	2.42	90.11
Colorado	2,786	2.50	80.22
Idaho	476	0.43	87.34
Montana	323	0.29	66.87
Nevada	574	0.52	84.41
New Mexico	854	0.77	75.24
Utah	790	0.71	94.61
Wyoming	252	0.23	94.74
Mountain Region	8,743	7.86	84.07
Alaska	424	0.38	86.89
California	21,852	19.65	91.32
Hawaii	1,146	1.03	78.49
Oregon	1,740	1.56	86.57
Washington	3,668	3.30	82.11
Pacific Region	28,830	25.92	89.11
U.S. Total	110,720	99.54	85.01
Other Total	508	0.46	35.23
GRAND TOTAL	111,228	100.00	84.47

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WOMEN VETERANS:

USAGE OF VA HOSPITALIZATION

by

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and

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FOREWORD

This is the second in a series of reports relating to the usage of veterans benefits by women. Historically, little data on women's usage of veterans benefits have been available because there have been so few women veterans, compared to male veterans. Hopefully, this report, together with the others in the series, will focus attention on women veterans and provide an initiative for discussions of present and future benefits for women veterans.

Many people have contributed to the development of this publication. Robert Robinson of the Biometrics Division was responsible for gathering much of the data and was assisted by Aurelia Colbert, Elnora Sexton, Elizabeth Ward, and Jean Wilson. Annie Basnight and Ruby McCrae typed draft manuscripts. Norman Hilier of Health Systems Information Service and Judy Vanderhoef of Reports Management Division reviewed the manuscript and provided comments. Denise Hazard of the Administrative Staff provided editorial assistance.

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EXECUTIVE SUMMARY

This report focuses on the use of VA hospitals by women veterans. Usage patterns among women veterans are compared with corresponding patterns among male veterans. Hospital usage patterns differ considerably by gender. Although lack of data on women veterans limits the extent to which real differences can be examined, this report may at least provide some direction for future analyses.

Since 1970, there has been a 60% increase in the number of VA hospital discharges among women veterans. This is due to the increase in the number of women in the Armed Forces over the last decade. The effect of this increase is felt most at the lower end of the age scale (under age 35); there have been both increased proportions of young women in the veteran population and increased proportions of young women among VA hospital discharges.

The age distributions of men and women discharged from VA hospitals are considerably different. The proportion of women discharged during Fiscal Year 1979 who were under the age of 35 is nearly double the corresponding proportion for men. Women veterans under the age of 45 experience higher hospital discharge rates than male veterans similarly aged, and men over the age of 45 experience higher discharge rates than females over the age of 45. Both VA data and data from a national survey of non-federal hospitals show that hospital usage rates for women climb sharply above age 55, though they lag behind usage rates for men. In light of an expected continuing rise in the number of women veterans, then, VA hospital usage by women can be expected to grow, in absolute terms. These facts point to the importance of age-gender patterns in planning for hospitalization benefits.

Male and female veterans who have been discharged from VA hospitals exhibit similar compensation and pension status.

In summary, this report underscores the importance of age-gender patterns of use among veterans for planners of VA hospitalization benefits. It also evidences the growing importance of women as active or potential beneficiaries of VA hospitalization.

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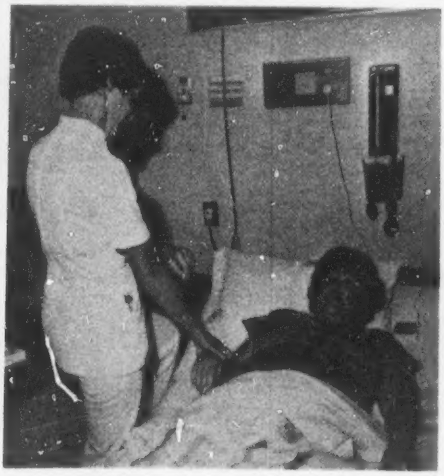
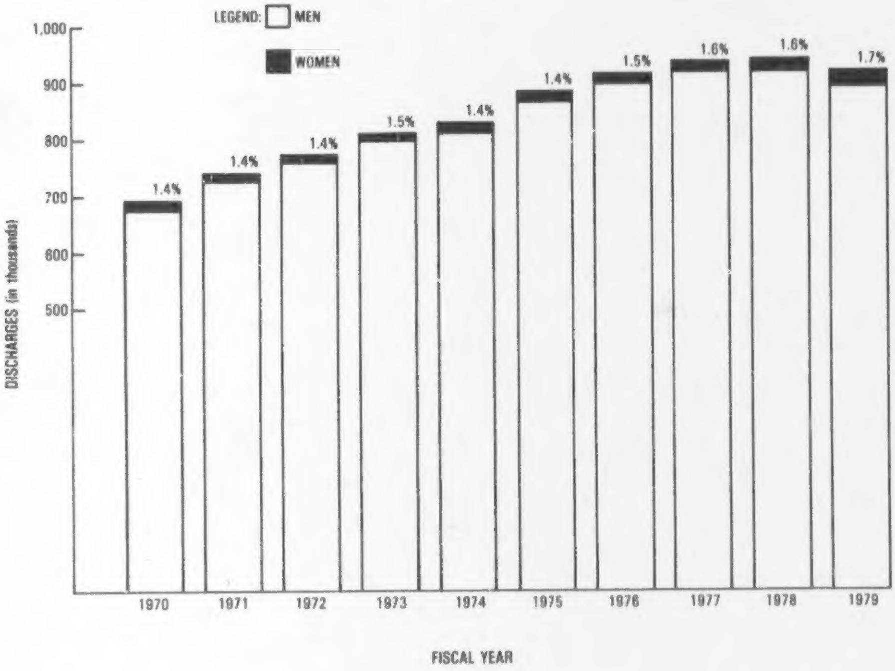


FIGURE 1. VA HOSPITAL DISCHARGES FOR MEN & WOMEN (FY70-79)



WOMEN VETERANS:
USE OF VETERANS ADMINISTRATION HOSPITALS

I. INTRODUCTION

Purpose

This report focuses on the use of Veterans Administration (VA) hospitalization benefits by women. The data in this report were assembled and the descriptive analysis focussed on women discharged from VA hospitals from 1970 through 1979. Data pertaining to the characteristics of female patients discharged from VA hospitals are compared to the corresponding data for male patients. The major topics of interest include: hospital discharge rates, age-specific hospital utilization, principal discharge diagnosis, and compensation and pension status of patients discharged.

The data which are reported here on women who use VA hospitals relate not only to women veterans but also to a small number of other women (see section II) who are eligible for and use VA hospitalization. The data are nevertheless descriptive of women veterans as a group, and therefore, all female beneficiaries of VA hospitalization benefits are referred to as women veterans in this report.

Source of Data

The data presented in this report are derived from the Veterans Administration's automated file of VA hospital discharges known as the Patient Treatment File (PTF). This file comprises a 100% enumeration of all VA hospital discharges. The PTF contains a separate record corresponding to each episode of hospitalization. For those persons with multiple episodes of hospitalization during any given year, a separate PTF record is generated corresponding to each such episode and included in the file for that year. The result is that individuals with multiple episodes of hospitalization during a given year are counted more than once in the annual figures reported on hospital discharges. On the other hand, incomplete hospital episodes (i.e., where the patient is not discharged during the fiscal year of admission) are not included in the totals reported.

II. CHARACTERISTICS OF HOSPITALIZATION BENEFICIARIES

Women Discharged from VA Hospitals

Female veterans currently make up a little more than 2% of the total veteran population. It is not surprising, then, that in contrast to male veterans relatively few women have been receiving treatment in VA hospitals. Figure 1 evidences the trend from Fiscal Year 1970. Since 1970, the proportion of VA hospital discharges accounted for by women has increased steadily, yet it has remained under 2%. This is in spite of the fact that there has been a notable increase (60%) in VA hospital discharges for women (from 9,600 to 15,300). There has been a corresponding 32% increase in hospital discharges for men (from 682,900 to 904,300) over the past decade; this fact emphasizes the disparity in the relative proportions of VA hospital discharges by gender (see Appendix Table A1). The 60% increase in the number of women discharged from VA hospitals over the last decade will be examined further in the following sections.

VA Hospital Usage and the Increasing Population of Women Veterans

As cited above, the historical data indicate that there are relatively few VA hospital discharges accounted for by women veterans. Traditionally, this has been due to the small number of women in the veteran population—but there are current indications that this situation is changing. Recent data[1] show that the gender-composition of active duty Armed Forces personnel has not remained static over the last decade, but that the proportion of women on active duty has increased noticeably. This is no doubt due in large part to the initiation of the all-volunteer Army in 1973 and its associated upbeat recruiting program. However, since the VA does not routinely collect Armed Forces separation data in its hospital records, it is not possible to study the effect of the reported increase in the number of female active duty personnel on VA hospital discharge rates. It is possible, though, to stratify the available data by age, keeping in mind that the effect of the recent increase in the proportion of women in the military is likely to be greatest in the younger age groups.

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[1] *Women comprised 1.4% of active duty service personnel at the end of Fiscal Year 1970 and 7.5% at the end of Fiscal Year 1979. (Source: "Selected Manpower Statistics", Department of Defense, 1980).*

For Fiscal Year 1979, Figure 2 shows the age-stratified percentages of women both in the veteran population and among VA hospital discharges. In particular, for Fiscal Year 1979, women comprised 2.3% of the total veteran population and accounted for 1.7% of all VA hospital discharges[2]. Figure 2 supports the supposition that the recent increase in the number of women in the Armed Forces has had its greatest impact at the lower end of the age scale (under age 35); greater proportions of women among young veterans (3.2%) and greater proportions of women among young veterans discharged from VA hospitals (3.0%) are both

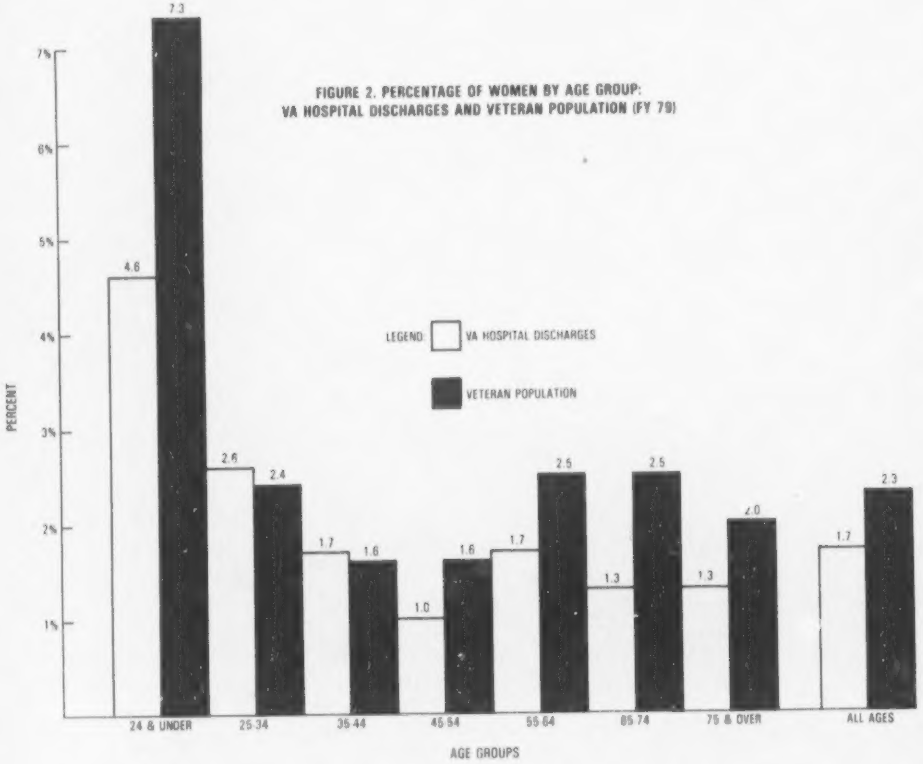

FIGURE 2. PERCENTAGE OF WOMEN BY AGE GROUP:
VA HOSPITAL DISCHARGES AND VETERAN POPULATION (FY 79)

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[2] *In Fiscal Year 1979, there were 679,000 women among the 30,072,000 veterans in the veteran population, and 15,311 women among the 919,609 discharges from VA hospitals.*

clearly evidenced (see Appendix Table A2). The simultaneous trends in the composition of the veteran population and in the population of VA hospital discharges are plotted in Figure 3, for veterans aged 24 and under.

Figure 3 shows that from Fiscal Year 1974 through Fiscal Year 1979 the percentage of women among young veterans rose steadily as did the percentage of young VA hospital discharges accounted for by women (see Appendix Table A3). With the continuing of the all-volunteer Army, and with the possibility of an eventual draft which could include women, the assumption of a continuing increase in the number of women in the Armed Forces is tenable. Under such an assumption, it is likely that the gender-related trends observed in the sub-population of young veterans and in the sub-population of young hospital discharges will also continue, and eventually extend to the higher age categories.

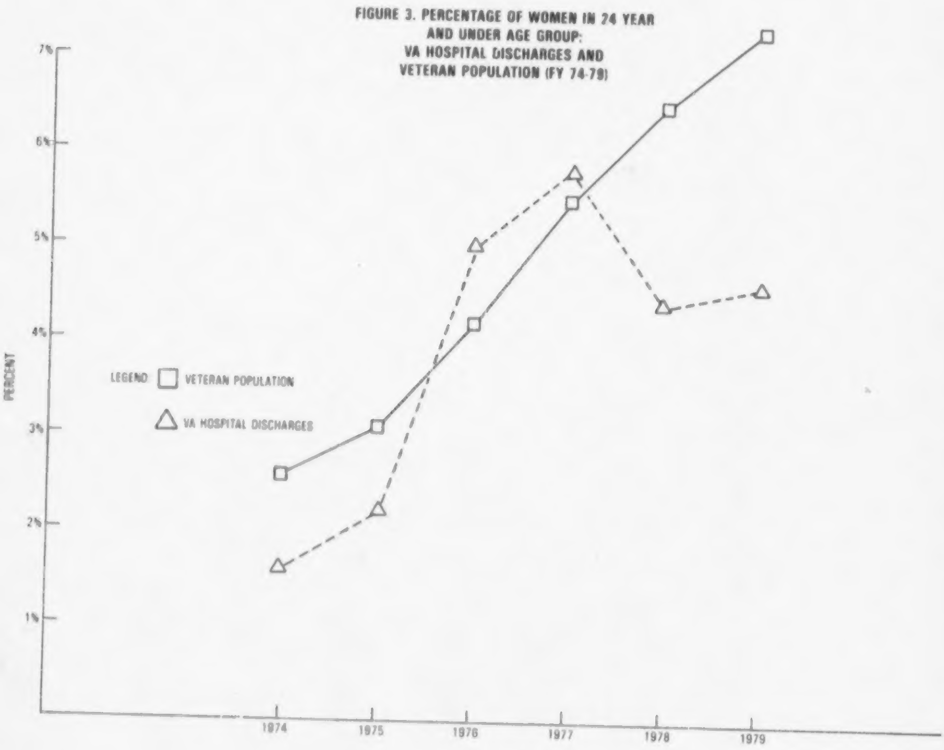

FIGURE 3. PERCENTAGE OF WOMEN IN 24 YEAR AND UNDER AGE GROUP: VA HOSPITAL DISCHARGES AND VETERAN POPULATION (FY 74-79)

Age-Specific VA Hospital Utilization

Figure 4 shows the age distributions of men and of women discharged from VA hospitals in Fiscal Year 1979. There are certain sharp differences in the two distributions, especially at the lowest (under 35) age level. Among women discharged from VA hospitals in Fiscal Year 1979, 26% were under age 35; among males discharged from VA hospitals in Fiscal 1979, 14% were under age 35. The difference is due in part to the increasing number of young women in the Armed Forces (see, for example, Figure 2).

Up to this point, discussion has centered on the usage of VA hospitals by women veterans, relative to other veterans. However, it is necessary to point out that even though women account for a small proportion of all VA hospital discharges, hospital usage among women veterans (within-group usage for women), *per se*, may actually be high, that is, within-group usage rates are of interest and should be examined. In some sense, within-group usage rates are better measures of VA benefit use since such rates control for the difference in the relative sizes of the male and female veteran sub-populations. Furthermore, since overall hospital usage tends to rise sharply with age, it is necessary to determine usage rates for each age group within the male and female veteran sub-populations. The resulting "age-specific" usage rates may then be compared by gender. Figure 4 presents Fiscal Year 1979 age-specific hospital usage rates for male and female veterans.

FIGURE 4. AGE DISTRIBUTION OF VA HOSPITAL DISCHARGES FOR MEN AND WOMEN (FY 79)

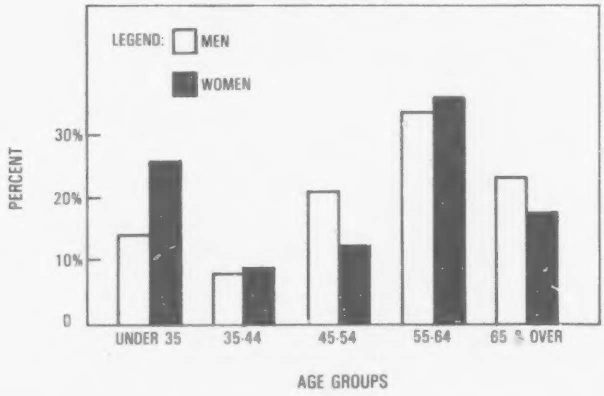

Figure 5 shows, for Fiscal Year 1979, that males experienced a higher overall rate of usage of VA hospitals than females; there were 31 VA hospital discharges for each 1,000 male veterans, and only 23 VA hospital discharges for each 1,000 female veterans. In Figure 5, the absolute difference between male and female hospital utilization rates increases with age, but among the 25-34 and 35-44 year age groups women actually show a slightly higher VA hospital usage rate than men (see Appendix Table A2). This is an important observation, but it does not refer to a veteran-specific phenomenon; data from the 1978 National Hospital Discharge Survey[3] indicate a similar pattern among individuals in the general population. For ages 15-44, women show a higher rate of usage of short-stay non-federal hospitals: 143 discharges per 1,000 women in contrast to 97 discharges per 1,000 men, excluding hospital episodes for infant deliveries among women. For ages 45-64, the rates are more nearly commensurate: 194 discharges per 1,000 women, contrasted with 192 discharges per 1,000 men. Among persons aged 65 or over, men experience a higher discharge rate: 412 per 1,000 men in contrast to 361 per 1,000 women. If hospital discharge rates are construed as indicators of use of hospitalization, then the crux of the issue is that an individual's use of hospitalization varies by age and gender in an important way: at the lower end of the age scale, women experience a higher use than men, while at the upper end of the age scale, men experience a higher use than women. It is only natural to suggest, then, that any future provision of hospitalization benefits should take into consideration the age-gender patterns of use within the population which is to be served.

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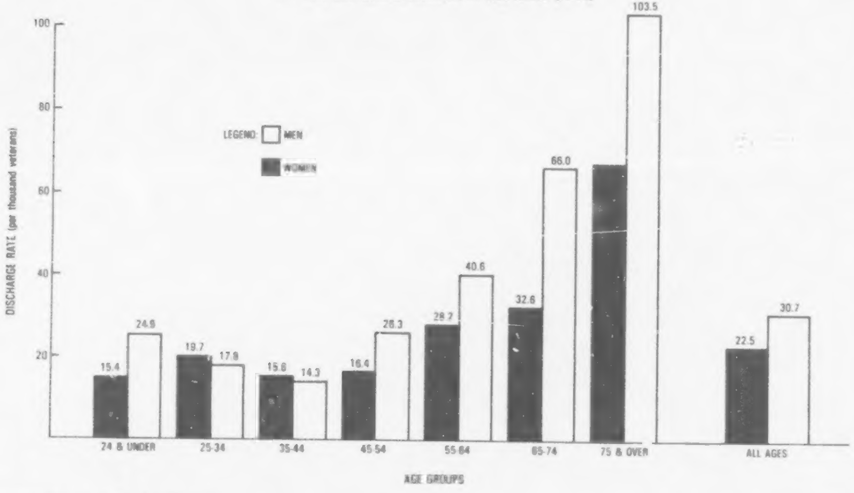
[3] *Utilization of Short-Stay Hospitals, DHEW Publication No. (PHS) 80-1797.*

FIGURE 5. VA HOSPITAL DISCHARGE RATE (per thousand) FOR MEN AND WOMEN VETERANS BY AGE GROUP (FY 79)



Compensation and Pension Status

Table 1 shows a comparison of compensation and pension status for men and women discharged from VA hospitals in Fiscal Year 1979. There is only one significant difference: 7% of all VA hospital discharges among women involved non-veterans compared to 0.6% among males discharged. The absolute number of non-veteran admissions to VA hospitals is very small, both among men and women. More detailed data by Fiscal Year are presented in Appendix Table A4, for Fiscal Year 1970 through Fiscal Year 1979.

Table 1
Compensation and Pension Status of Men and
Women Discharged From VA Hospitals:
Fiscal Year 1979

All VA Hospital Discharges	Men	Women
Total	(904,000) 100%	(15,300) 100%
Treated for Service-Connected Condition	11	13
Service Connected: Treated For Non-Service Connected Condition	17	13
Non-Service Connected: Pension	21	18
Non Service Connected: No Pension	51	49
Non-Veterans[1]	1	7

[1] *The term "non-veterans" is meant to include: patients such as active duty military, humanitarian emergency cases, reimbursable cases, and allied beneficiaries (spouses and children of 100% disabled veterans or of veterans who died as a result of military service are eligible for medical care in VA facilities). Also, if a veteran is admitted as an Office of Workers Compensation Program case, that veteran's record is coded "non-veteran."*

Medical Diagnosis

For men and women discharged from VA hospitals in Fiscal Year 1979, Figure 6 shows a comparison of their principal medical diagnoses. It is that diagnosis which is responsible for the major portion of a patient's hospital stay. In Figure 6, it is coded into four broad categories: Psychotic, Psychiatric, Neurological, and General Medical and Surgical. Overall, the distributions for males and females are similar, although there are relatively more principal diagnoses of psychotic disorders reported among women discharged, and fewer other psychiatric diagnoses. Over the ten year period from Fiscal Year 1970 through Fiscal Year 1979, women discharged from VA hospitals experienced higher proportions of psychotic diagnoses than men (Appendix Table A5). In Table 2, medical diagnosis is broken out in finer detail, for selected conditions and for selected years (Fiscal Years 1970, 1975, and 1979). Appendix Table A6 contains the complete diagnostic list for these years.

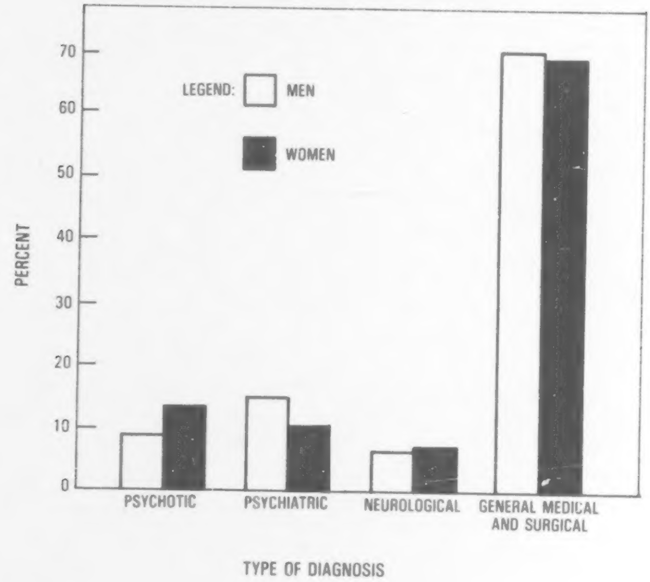
The "all diagnoses" category is included in Table 2 in order to provide a baseline category for comparison, and this category shows the reported rise in the proportion of VA hospital discharges for women between 1970 and 1979 (compare with Figure 1). There are relatively more women in the "all psychoses" category than in the categories "all neurological diseases", "neoplasms: malignant", and "accidents and adverse effects", which are all more nearly like the baseline category in this respect. Percentages reported in the "neoplasms: benign" category are about 2 1/2 times the corresponding baseline percentages, for the three years under consideration. This is probably due to the relatively frequent occurrence of benign breast and uterine lesions among women. The very large percentages of women reported in the category of "diseases of breast, gynecological disorders, and complications of pregnancy" are to be expected.

Table 2
Total Number and Percent of VA Hospital Discharges for Women for Selected Diagnoses: FY 70, FY 75, FY 79

	Total VA Hospital Discharges (000's) and Percent Women		
Diagnosis	1970	1975	1979
All diagnoses	692.5 (1.4)	883.4 (1.4)	919.6 (1.7)
All psychoses	58.2 (2.6)	73.0 (2.1)	78.5 (2.5)
All neurological diseases	43.0 (1.2)	53.9 (1.4)	58.1 (1.7)
Neoplasms: malignant	46.3 (1.1)	63.9 (1.2)	81.7 (1.4)
benign	5.4 (3.5)	8.9 (3.3)	10.6 (3.3)
Accidents: adverse effects of substances; complications of trauma, therapy & surgery	45.3 (1.5)	51.5 (1.7)	48.1 (1.9)
Diseases of breast, gynecological disorders, and complications of pregnancy	1.1 (44.0[1])	1.7 (39.6[1])	1.5 (47.6[1])

[1] *Women do not account for 100% of this category because the category includes diseases of the breast which, although rare, do occur in men.*

FIGURE 6. TYPE OF DIAGNOSIS OF VA HOSPITAL DISCHARGES FOR MEN AND WOMEN (FY 79)



III. CONCLUSION

The available data on women veterans' usage of VA hospitalization benefits show that the number of women beneficiaries of VA hospitalization benefits is growing. This trend is expected to continue. The immediate demand for hospitalization occurs among young women veterans but, in the long run, demand for medical services will be increased among older women veterans as well. However, the lack of data on women veterans precludes any attempt to clarify specific future requirements in terms of services and suggests the need for an examination of patterns of use in the population which is to be served. Such information cannot be obtained from those sources currently available within the VA.

APPENDIX TABLES

A1	VA Hospital Discharges by Sex, FY 70-79
A2	VA Hospital Discharges and Veteran Population by Sex and Age Group: FY 79
A3	VA Hospital Discharges and Veteran Population, Percentage of Women, Ages 24 and Under: FY 72-79
A4	VA Hospital Discharges by Compensation and Pension Status and Sex: FY 70-79
A5	VA Hospital Discharges by Sex and Type of Diagnosis: FY 70-79
A6	VA Hospital Discharges, Percentage of Women, by Detailed Diagnosis: FY 70, FY 75, FY 79

Appendix

Table A1
Number and Percent of Men and Women Discharged from VA Hospitals: FY 70-79

Fiscal Year	Total Discharged	Sex			
		Number of Males	Percent Male	Number of Females	Percent Female
1970	692,518	682,899	98.61	9,619	1.39
1971	742,853	732,688	98.63	10,165	1.37
1972	776,227	765,239	98.58	10,988	1.42
1973	812,537	800,657	98.53	11,880	1.47
1974	827,245	815,848	98.62	11,397	1.38
1975	883,350	870,824	98.58	12,526	1.42
1976	915,302	901,234	98.46	14,068	1.54
1977	934,662	919,582	98.39	15,080	1.61
1978	936,515	921,157	98.36	15,358	1.64
1979	919,609	904,298	98.34	15,311	1.66

Table A2
VA Hospital Discharges, Veteran Population[1], and VA Hospital Discharge Rate for Men and Women by Age Group: FY 79

Age Group	VA Hospital Discharges		Veteran Population[1] (in thousands)		VA Hospital Discharge Rate[2]	
	Women	Men	Women	Men	Women	Men
24 and under	1,263	26,109	82	1,049	15.4	22.9
25 – 34	2,771	102,948	141	5,782	19.7	17.8
35 – 44	1,278	73,580	82	5,134	15.6	14.3
45 – 54	1,932	192,405	118	7,308	16.4	26.3
55 – 64	5,357	301,716	190	7,429	28.2	40.6
65 – 74	1,628	126,285	50	1,914	32.6	66.0
75 and over	1,068	80,423	16	777	66.8	103.5
Age unavailable	144	832	–	–	–	–
Total	15,311	904,298	679	29,393	22.5	30.7

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[1] *Veteran population estimated as of September 30, 1979.*

[2] *Rates are VA hospital discharges per thousand veterans in population.*

Table A3
Number and Percent of Women in 24 Year and Under Age Group: Veteran Population and VA Hospital Discharges: FY 72-79

Fiscal Year	Veteran Population (Age 24 and Under Only)	Percent Women	VA Hospital Discharges (Age 24 and Under Only)	Percent Women
1972	32,000	1.8	—[1]	—[1]
1973	29,000	2.1	—[1]	—[1]
1974	31,000	2.6	784	1.63
1975	33,000	3.1	958	2.21
1976	48,000	4.2	1,212	5.02
1977	64,000	5.5	1,340	5.82
1978	75,000	6.5	1,384	4.44
1979	82,000	7.3	1,263	4.61

[1] *Data not available.*

Table A4
Number and Percent of VA Hospital Discharges for Men and Women by Compensation and Pension Status: FY 70-79

		MEN							WOMEN						
Fiscal Year	Total Discharges	Total	SC 10% or More	SC Less Than 10%	NSC/SC	NSC W/Pension	NSC No Claim Pending	Non-Vet	Total	SC 10% or More	SC Less Than 10%	NSC/SC	NSC W/Pension	NSC No Claim Pending	Non-Vet
1970	692,518	682,899	14.22	.91	15.53	26.19	41.97	1.18	9,916	13.87	1.18	13.23	19.99	45.20	6.53
1971	742,853	732,688	14.38	.67	15.84	25.16	42.80	1.15	10,165	14.39	.74	13.50	19.83	45.34	6.20
1972	776,227	765,239	13.26	.50	15.65	24.60	44.49	1.30	10,988	13.15	.50	13.46	20.41	45.04	7.44
1973	812,537	800,657	12.08	.36	16.10	24.70	45.67	1.09	11,880	11.68	.33	13.35	21.64	45.10	7.90
1974	827,245	815,848	11.14	.32	15.69	22.71	48.93	1.16	11,397	11.81	.36	13.05	19.96	46.77	8.05
1975	833,350	870,824	11.87	.41	13.34	21.77	51.67	.94	12,526	12.22	.40	11.28	17.25	50.31	8.54
1976	915,302	901,234	10.35	.25	14.22	21.65	52.74	.79	14,068	10.58	.37	11.81	18.28	50.43	8.53
1977	934,662	919,582	9.64	.21	15.06	22.06	52.35	.68	15,080	10.72	.29	12.47	17.40	51.76	7.36
1978	936,515	921,157	9.71	.13	15.44	22.49	51.56	.62	15,358	11.51	.18	13.00	17.74	50.69	6.88
1979	919,609	904,298	10.46	.27	16.65	21.38	50.69	.55	15,311	12.17	.43	13.03	18.31	49.08	6.98

Table A5
Number and Percent of VA Hospital Discharges for Men and Women by Type of Diagnosis: FY 70-79

Type of Diagnosis	1970		1971		1972		1973		1974	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Total	682,899	9,619	732,688	10,165	765,239	10,988	800,657	11,880	815,848	11,397
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
TB Total	9,214	45	8,529	34	7,370	30	6,927	31	6,261	14
Percent	1.35	.47	1.17	.34	.96	.27	.87	.26	.77	.12
Psychoses – Total	56,710	1,491	65,016	1,587	63,361	1,438	65,305	1,533	69,230	1,540
Percent	8.30	15.15	8.87	15.61	8.28	13.09	8.16	12.90	8.49	13.51
Psychiatric – Total	87,867	1,374	98,789	1,397	112,983	1,442	126,699	1,553	136,189	1,498
Percent	12.87	14.28	13.48	13.74	14.77	13.12	15.82	13.07	16.69	13.15
Neurological – Total	42,489	512	44,982	579	45,774	623	48,294	697	49,765	757
Percent	6.22	5.32	6.14	5.70	5.98	5.67	6.03	5.87	6.10	6.12
GM&S – Total	486,619	6,197	515,372	6,568	535,751	7,455	553,432	8,066	554,403	7,588
Percent	71.26	64.43	70.34	64.61	70.01	67.85	69.12	67.90	67.95	66.58

Table A5 (cont'd)
Number and Percent of VA Hospital Discharges for Men and Women by Type of Diagnosis: FY 70-79

Type of Diagnosis	1975		1976		1977		1978		1979	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Total	870,824	12,526	901,234	14,068	919,582	15,080	921,157	15,358	904,298	15,311
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
TB – Total	5,817	23	5,248	36	4,950	23	4,366	26	3,812	17
Percent	.67	.18	.58	.26	.54	.15	.47	.17	.42	.11
Psychoses – Total	71,515	1,511	71,741	1,657	73,351	1,752	75,813	1,823	76,556	1,936
Percent	8.21	12.06	7.96	11.78	7.98	11.62	8.23	11.87	8.47	12.64
Psychiatric – Total	144,144	1,608	145,422	1,749	138,271	1,646	134,683	1,701	132,305	1,685
Percent	16.55	12.84	16.14	12.43	15.04	10.91	14.62	11.08	14.63	11.01
Neurological – Total	53,141	766	55,594	875	57,413	951	50,092	951	57,112	1,009
Percent	6.10	6.12	6.17	6.22	6.24	6.31	6.31	6.19	6.31	6.59
GM&S – Total	596,207	8,618	623,229	9,751	645,597	10,708	648,203	10,857	634,513	10,664
Percent	68.47	68.80	69.15	69.31	70.21	71.01	70.37	70.69	70.17	69.95

Table A6
Patients Discharged From VA Medical Centers By Diagnostic Groups Showing Number and Percent of Females Discharged: FY 70, 75, 79

Diagnosis	FY 1970			FY 1975			FY 1979		
	Total	Female		Total	Female		Total	Female	
		Number	Percent		Number	Percent		Number	Percent
Active Pulmonary Tuberculosis	6,102	28	0.5	3,959	13	0.3	2,602	5	0.2
Active Tuberculosis: Other Forms	816	6	0.7	783	5	0.6	835	11	1.3
Observation and Examination, Administrative Admission and Late Effects	2,341	11	0.7	1,098	5	0.5	392	1	0.3
TUBERCULOSIS TOTAL	9,259	45	0.5	5,840	23	0.4	3,829	17	0.4
Alcoholic Psychosis and All Other Psychotic Disorders	48,073	1,402	2.9	72,774	1,509	2.1	78,257	1,934	2.5
Psychosis Associated with Drug Dependence	10,128	89	0.9	242	2	0.8	235	2	0.9
PSYCHOSES TOTAL	58,201	1,491	2.6	73,016	1,511	2.1	78,492	1,936	2.5
Alcoholism and All Other Non-Psychotic Mental Disorders	29,944	859	2.9	123,270	1,464	1.2	118,269	1,520	1.3
Drug Dependence	51,561	427	0.8	14,442	74	0.5	8,936	97	1.1
Non-Psychotic Organic Brain Syndrome, Associated with Other Physical Conditions	7,736	88	1.1	8,032	70	0.9	6,785	68	1.0
OTHER PSYCHIATRIC TOTAL	89,241	1,374	1.5	145,744	1,608	1.1	133,990	1,685	1.3
Vascular Lesions Affecting Central Nervous System	12,625	117	0.9	16,242	165	1.0	18,062	198	1.1
Other Neurological	29,694	388	1.3	36,801	587	1.6	39,170	785	2.0
Neurological Diseases/Sense Organs	682	7	1.0	864	14	1.6	889	26	2.9
NEUROLOGICAL TOTAL	43,001	512	1.2	53,907	766	1.4	58,121	1,009	1.7

Table A6 (cont'd)
Patients Discharged From VA Medical Centers By Diagnostic Groups Showing Number and Percent of Females Discharged: FY 70, 75, 79

Diagnosis	FY 1970			FY 1975			FY 1979		
	Total	Female		Total	Female		Total	Female	
		Number	Percent		Number	Percent		Number	Percent
Syphilis, Other Than Psychotic	299	1	0.3	239	–	–	189	5	2.6
Infective and Parasitic Diseases, NEC	10,554	115	1.1	9,463	150	1.6	9,063	205	2.3
Malignant Neoplasms	46,270	493	1.1	63,929	791	1.2	81,692	1,127	1.4
Benign and Unspecified Neoplasms	5,466	192	3.5	8,943	291	3.3	10,609	348	3.3
Endocrine Nutritional and Metabolic Diseases	21,103	332	1.6	25,947	430	1.7	27,918	528	1.9
Heart Diseases and Symptoms	54,294	425	0.8	73,462	641	0.9	85,040	786	0.9
Other Circulatory Diseases	31,966	324	1.0	42,828	503	1.2	39,200	427	1.1
Acute Respiratory Diseases and Symptoms, with Asthma	18,793	168	0.9	16,832	204	1.2	15,729	214	1.4
Other Respiratory Diseases	39,822	350	0.9	50,410	488	1.0	53,550	750	1.4
Diseases of the Buccal Cavity	3,543	45	1.3	4,998	85	1.7	5,107	138	2.7
Diseases of the Appendix	1,460	9	0.6	12,269	13	1.0	1,359	21	1.5
Hernia of Abdominal Cavity	17,482	82	0.5	19,816	91	0.5	19,667	119	0.6
Alcoholic Cirrhosis of Liver	55,832	705	1.3	66,505	850	1.3	9,511	64	0.7
Other Diseases of the Digestive System and Symptoms	–	–	–	–	–	–	60,066	1,087	1.8
Diseases of Urinary System and Symptoms	22,531	324	1.4	25,846	483	1.9	26,469	460	1.7
Disease of Male Genital Organs	15,425	–	–	18,431	–	–	19,709	–	–

Table A6 (cont'd)

Patients Discharged From VA Medical Centers By Diagnostic Groups Showing Number and Percent of Females Discharged: FY 70, 75, 79

Diagnosis	FY 1970			FY 1975			FY 1979		
	Total	Female		Total	Female		Total	Female	
		Number	Percent		Number	Percent		Number	Percent
Disease of Breast, Gyn Disorders and Complications of Pregnancy	1,125	495	44.0	1,651	653	39.6	1,505	717	47.6
Disorders of Sense Organs	16,846	175	1.0	20,622	307	1.5	22,067	335	1.5
Diseases of Skin and Cellular Tissue	20,532	192	0.9	23,102	283	1.2	20,886	343	1.6
Diseases of Bones and Organs of Movement and Symptoms	33,494	602	1.8	41,699	834	2.0	39,563	1,079	2.7
Accidents, adverse effects of chemical substances and complications of Trauma, Therapy and Surgery	45,312	678	1.5	51,454	657	1.7	48,143	936	1.9
Miscellaneous Diseases and Conditions	12,486	223	1.8	17,886	324	1.8	20,125	427	2.1
Observation and Examination, Administrative GM&S	18,201	267	1.5	19,493	340	1.7	28,030	548	2.0
GENERAL MEDICAL AND SURGICAL TOTAL	492,816	6,197	1.3	604,825	8,618	1.4	645,177	10,644	1.7
GRAND TOTAL	692,518	9,619	1.4	883,350	12,526	1.4	919,609	15,311	1.7